# List of Hospital-wide/Department Policies & Procedures

Submitted to JCC for Approval on May 12, 2015

## 1. New Policies and Procedures (P & P)

**Hospital-wide: Laguna Honda Hospital Policies & Procedures (LHHPP) approved by NEC, MEC and/or HEC**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Development</th>
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</thead>
<tbody>
<tr>
<td>LHHPP 28-01</td>
<td>Community Outing Program</td>
<td>Transforms an Activity Therapy Department P &amp; P into a hospital-wide P &amp; P comprising of interdisciplinary collaboration for providing a safe and meaningful community outing program on a monthly basis for the many residents at Laguna Honda</td>
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## 2. Revised Policies and Procedures

**Hospital-wide: Laguna Honda Hospital Policies & Procedures (LHHPP) approved by NEC, MEC and/or HEC**

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<tr>
<td>LHHPP 01-12</td>
<td>Compliance Program</td>
<td>Clarifies the P &amp; P that the compliance program at Laguna Honda campus applies to employees at the Hospital and Health at Home; and elaborates on the procedures of the compliance program that includes the Compliance Officer, Compliance Committee, compliance training, compliance standards and policy and procedures, reporting of compliance issues, investigating of compliance issues, and auditing and monitoring activities</td>
</tr>
<tr>
<td>LHHPP 20-04</td>
<td>Discharge Planning</td>
<td>Deletes Procedure 3, 5c (xv), and 5f (ii) to reflect current processes; adds Resident Care Team (RCT) responsibilities, including rehab services, to identify resident need for rehab services and treatment; revises and clarifies Social Service functions in preparing and orienting the resident to the discharge plan (including documentation). Other minor edits include spelling out abbreviations that are only used once in the policy and procedure.</td>
</tr>
<tr>
<td>LHHPP 20-07</td>
<td>Against Medical Advice</td>
<td>Clarifies the P &amp; P on a resident choosing to leave against medical advice from Laguna Honda by removing policy and procedure statements about a resident who is absent without leave (AWOL)</td>
</tr>
<tr>
<td>LHHPP 25-02</td>
<td>Safe Medication Orders</td>
<td>Revised to include prescription orders that are electronic, removes Future Issues, clarifies how medication range orders are to be prescribed, and corrects typographical errors</td>
</tr>
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*HEC – Hospital Executive Committee; MEC – Medical Executive Committee; NEC – Nursing Executive Committee*
Substitutes the job category “Advance Practice Nurse” to “Affiliated Healthcare Practitioners” as a broader term that may include other clinicians that are credentialed by the Medical Staff such as the Clinical Pharmacist; and makes other procedural changes to include the use of the electronic health record.

Re-titled to “Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus.” Adds policy statement No. 2, and a procedure that businesses must provide a copy of their Seller’s Permit at the same time that an application is completed. A copy of the Application (Part A) and Invoice (Part B) forms are also added to the revised P & P.

Re-titled to “Meeting and Event Reservations by Community Groups.” Policy No. 2 is revised stating that persons or organizations applying to use a meeting or event space must also comply with City and Laguna Honda campus use policies, and a 3rd policy statement is added specifying that any Laguna Honda staff may be a sponsor of a non-Laguna Honda group/event. The Procedures section further detail additional requirements when applying and using the Laguna Honda campus for non-Laguna Honda groups. The Application (Part A) and Invoice (Part B) forms are also added to the revised P & P.

Re-titled to “Physician Notification of Change in Resident Status.” Adds policy statements to include availability of the licensed nurse to provide pertinent assessment information and assistance as necessary when the physician arrives to evaluate the resident; notification of the family or surrogate decision-maker; and communication of non-urgent clinical issues to the primary care physician. Revises Appendix A by adding N for Now based on the urgency of the situation to SBAR (situation, background, assessment, recommendation) and specifies that communication with the physician is done verbally.

Re-titled to “Tub Baths and Showers” (as bathing includes nail care, hair care, shaving, and

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<tr>
<td>NPP J6.0</td>
<td>Intravenous (I.V.) Therapy Maintenance</td>
<td>Revises nursing practice by changing the frequency of peripheral IV site change from 72 hours to 96 hours based on 2011 CDC recommendation; and deletes duplicate procedures on IV push medications that are described in another Nursing P &amp; P</td>
</tr>
<tr>
<td>K 2.0</td>
<td>Wound Assessment and Management</td>
<td>Revised to enhance wound assessment and management practices by licenses nurses; adds background information on defining different types of wounds, characteristics and best practices for management; and adds Attachments 1 and 2 regarding the two-layer compression bandage system; and skin substitutes and extracellular matrix products, respectively</td>
</tr>
<tr>
<td>NPP M 11.0</td>
<td>Warmer Cabinet Protocol</td>
<td>Re-titled to “Blanket Warmer Protocol,” establishes temperature lower limit at 80 degrees Fahrenheit, and adds Appendix 1 as a quick reference for operating the blanket warmer</td>
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<tr>
<td>LHHPP 29-08</td>
<td>Laguna Honda Hospital Temporary Morgue Services</td>
<td>For deletion because temporary morgue services by Bay Area Cremation and Funeral Services are no longer contracted or needed</td>
</tr>
<tr>
<td>LHHPP 72-01 Infection Control Manual (ICM) A3</td>
<td>Infection Control Professionals</td>
<td>For deletion because it is duplicative of LHHPP 72-01 Infection Control Manual A1 Authority of the Infection Control Committee (ICC) that describes the Infection Control Program at Laguna Honda, ICC membership and functions</td>
</tr>
<tr>
<td>LHHPP 72-01 ICM A4</td>
<td>Demographics of Laguna Honda</td>
<td>For deletion because the P &amp; P is unnecessary as Laguna Honda’s infection control surveillance includes all in-house residents/patients</td>
</tr>
<tr>
<td>LHHPP 72-01 ICM A6</td>
<td>Nosocomial Infection Definitions</td>
<td>For deletion because Laguna Honda uses the McGeer criteria for infection control surveillance to determine healthcare acquired and community acquired infections</td>
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*HEC – Hospital Executive Committee; MEC – Medical Executive Committee; NEC – Nursing Executive Committee*
COMMUNITY OUTING PROGRAM

POLICY:

1. The Activity Therapy plans, coordinates and implements community outings for residents of Laguna Honda Hospital.

2. Staff other than Activity Therapy staff may lead resident community outings when appropriate.

3. Department managers are responsible for providing staff with necessary safety training prior to outings.

PURPOSE:

The goals of program are to:

1. Provide safe, meaningful outdoor experiences and enhance the quality of life for residents.

2. Reduce the isolation resulting from long term hospitalization.

3. Promote a sense of normalcy though contacts with the surrounding community.

4. Promote the reintegration of residents back into the community by providing an opportunity for skill building.

PROCEDURE:

1. Types of Outings
   a. Neighborhood group outings
      Group outings (with 6 or more attendees) led by the assigned Neighborhood Activity Therapy team.
   b. City tour outings
      Small group outings (between 1-3 attendees) are generally coordinated by the assigned Neighborhood Activity Therapist and staffed by nursing. The goal of the outing is to provide opportunities for residents who, due to medical or behavioral challenges, have difficulty participating in the typical neighborhood group outings.
   c. Discharge related/ community re-integration outings
      These are individualized outings designed to support the resident’s community re-integration.
d. Hospital-wide specialty trips

These are special community outings that result from the purchase or donation of special event tickets, special activity or community event. This is also an opportunity for a select group of residents with particular interests to socialize in the community.

2. Education and Training

a. List of mandatory education/training and certification/licensure for drivers:

i. CNA certification;
ii. Basic Life Safety CPR certification;
iii. Class B driver’s license;
iv. Trained to complete vehicle safety checks prior to each trip using the Driver’s bus condition report;
v. Complete initial and annual competency training;
vi. Trained to manage vehicle operations within the bus; and
vii. Trained to complete the driver checklist prior to departure and return from community outings.

b. List of mandatory education and training for Activity Therapists:

i. Orientation training on procedures including the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” form, the “Staffing guidelines for community outings”, Restaurant outing list information, funding protocols;
ii. Scheduled to shadow veteran staff on a trip to see environmental safety assessment during the trip, etc;
iii. Provided with opportunity to practice using muni with residents;
iv. Orientation to the Driver competencies and checklist;
v. If using the van, provide proof of a driver’s license and complete an initial van competency test.

c. Nurse Managers and Charge nurses are provided instruction on the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” form and the “Staffing guidelines for community outings”.

d. Staff who regularly attend outings shall participate in annual trainings, review best practices, evaluations of new destinations and practice emergency procedures which includes a safety guidebook.

e. All staff and volunteer(s) participating in any outing shall attend a pre-outing safety huddle prior to departure.

f. Family members participating in any outing shall receive individual instructions related to the outing.
3. Transportation

Several methods of transportation can be used to facilitate the above outings and may include the following:

a. The Environmental Services department maintains buses that require a class B license to operate. They are inspected by the drivers each day they are used for an outing and are maintained by the city vehicle maintenance shop. Drivers are CNA certified.

b. The Activity Department has a small wheelchair accessible van that can accommodate a small trip. It is also maintained by the city. Orientation and training is provided to staff prior to use.

c. Public transportation is used when providing training to residents re-integrating into the community. Training for muni use is provided by shadowing another staff member in the AT department.

4. Planning

The Activity Therapy staff are responsible for leading the overall outing effort, which includes focusing on resident enjoyment and safety, securing offsite logistics, facilitating operational procedures and coordinating support staff. Planning activities include coordinating the steps a through f described below.

a. Creating and coordinating a monthly schedule of outings.

b. Using the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” form, the staff member determines the residents who are scheduled to attend the outing, costs and other resources needed to support the activity, and processes the paperwork prior to the scheduled outing. The form includes consideration of the ten items listed below.

   i. Physician order to participate – A resident must be living at Laguna Honda for at least 2 weeks before being considered to participate in an outing;
   ii. Dietary limitations;
   iii. Resident supervision – On the day of the community outing, the team determines the level of supervision necessary for each resident attending;
   iv. DNR status;
   v. Bag lunch request if needed;
   vi. Volunteer request – All volunteers are processed through the Volunteer department;
   vii. Funding request;
   viii. Nurse Manager signature – Signifies that the list of residents and clinical information has been reviewed and there is agreement on participation;
ix. Activity Therapy Supervisors signature – Signifies that the form has been correctly completed, the trip is appropriate for the goals it’s being planned for and that other operational needs are addressed;

x. Prior to going on the community outing, nursing re-assesses the resident for any issues that may preclude their participation.

c. Using the “Staffing guidelines for community outings”, Nursing and Activity Therapy staff determine the necessary staff support for a safe and enjoyable outing. Activity Therapy staff are responsible for obtaining receipts for compliance with City Controller's requirements. Activity Therapy adhere to the spending guidelines to control costs by creating an outing budget, and monitor the spending. Activity Therapy are responsible for managing the usage of FastTrak provided by the Accounting Department

d. Activity Therapy staff collaborates with the resident to determine the resident's personal spending options to meet the resident’s outing goals or discharge related needs.

e. Activity Therapy staff collaborates with Rehabilitation staff to address functional improvements and potential appointment conflicts.

f. Activity Therapy staff collaborates with interested family members to confirm that spending guidelines and safety measures will be followed.

5. Day of the Outing

a. Funds for the outing are provided to the Activity Therapist by the Activity Therapy Supervisor, as needed.

b. Activity Therapy staff meet to review the planning form and discuss logistics.

c. Activity Therapy and neighborhood nursing staff huddle to review residents for changes in condition, supervision needed and staffing support.

d. Residents who are assessed as unable to go out on pass independently shall receive, at minimum, line of sight supervision for safety during community outings.

e. Buses are loaded outside of the main lobby.

f. Drivers complete the Checklist of the "Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request" form.

g. After the outing, Activity Therapy staff will promptly submit attendance and/ or funds and receipts to Activity Therapy Supervisor to process. Supervisors will complete the Gift Fund Reimbursement form.

a. Standard emergency protocol for CPR and first aid shall be used for medical emergencies. 911 emergency services shall be called as necessary.

b. The neighborhood Nurse Manager or Charge Nurse, and the Activity Therapy Supervisor shall be contacted immediately when an untoward event or medical emergency occurs for decision support in addressing the needs of the group.

7. Evaluation and Quality Assurance

a. Outings coordinated by the Activity department are monitored by Activity Therapy Supervisors who regularly assess the quality of outings.

b. Community outing data is collected and tracked by the Activity Therapy Department.

c. Data is shared with the Activity Therapy staff and neighborhood nursing leaders.

d. Information is used to develop ongoing training.

e. Clinical events that occur during the outing shall be reviewed by the Resident Care Team, no later than the next business day.
ATTACHMENT:
None

REFERENCE:
LHHPP 24-01 Missing Resident Procedures
LHHPP 76-02 Smoke and Tobacco Free Environment
CPR and First Aid for health care providers guidelines
Driver’s bus condition report
Laguna Honda initial and annual bus driver competency checklist
Staffing guidelines for community outings
Therapeutic outing planning guide, resident assessment and bag lunch request
Van trips management competency checklist

Revised: N/A
Original adoption: 15/05/12 (Year/Month/Day)
COMPLIANCE PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) maintains a Compliance Program consistent with the Department of Public Health (DPH) Compliance Office’s policies and procedures and with federal and state regulations, including the Federal and California False Claim Act.

2. The Compliance Program at the Laguna Honda campus applies to all Laguna Honda and Health at Home employees, and all Laguna Honda campus contractors and agents who, on behalf of Laguna Honda, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, or monitor the provision of health care services.

3. Laguna Honda maintains a Quality Assurance and Performance Improvement (QAPI) program, as a component of its Compliance Program that meets the QAPI standards set forth in the Center for Medicare and Medicaid Conditions of Participation.

PURPOSE:

1. To ensure the integrity in and of Laguna Honda campus clinical and business activities by adhering to the following goals:
   a. To promote an understanding of and compliance with Medicare, Medi-Cal, and other applicable federal and state laws and regulations;
   b. To use education and training to improve compliance with documentation, coding, billing and reimbursements rules and regulations; and
   c. To work with providers, managers, and staff to integrate compliance into the daily operations of Laguna Honda.

PROCEDURE:

1. Laguna Honda is committed to comply with all applicable federal and state statutes and regulations related to billing for services. To this end, it maintains a Compliance Program that includes procedures 2 through 8.

2. Compliance Officer

   The Compliance Officer is responsible for the daily operation of the Compliance Program at the Laguna Honda campus that includes:
   a. Overseeing and monitoring the implementation and maintenance of the Compliance Program.
   b. Reporting on a regular basis to the Laguna Honda Compliance Steering Committee (no less than quarterly) to review and conduct compliance activities. The Compliance Committee shall consist of the Compliance Officer as Chair, Chief

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Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Quality Director, Health at Home Administrator, Deputy City Attorney, and designated staff from Patient Financial Services, Health Information Services, and Utilization Management. Other staff may be appointed to the committee or invited to committee meetings as deemed necessary by the Chair.

c. Periodically reassessing the Compliance Program to identify necessary changes due to findings from compliance activities, changes in business practices or processes, and new regulations and risks.

d. Coordinating internal compliance review and monitoring activities.

e. Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.

f. Presenting a Compliance report to the DPH Health Commission, through the Laguna Honda Hospital Executive and Joint Conference Committee, no less than annually.

3. Compliance Committee

The Laguna Honda Compliance Steering Committee, chaired by the Compliance Officer, consists of senior managers who are responsible for ensuring integrity in the clinical and business operations of Laguna Honda Hospital and Health at Home. The Committee shall report to the Laguna Honda Executive Committee and function as an oversight committee with sub-committees and work groups tasked to research/resolve particular issues as they arise. This includes ensuring that the Compliance Program is effective at identifying and mitigating risks by:

a. Approving Compliance Program policies and procedures, bi-annual risk assessments, and the annual work plan, including periodic updates of those documents.

b. Monitoring compliance program activities through regular reports from the Compliance Officer.

c. Allocating adequate resources to address compliance risks, including designating department staff to partner with the Compliance Office on compliance monitoring projects, and tasking work groups as necessary.

4. Compliance Training

Laguna Honda, through its Compliance Officer, shall ensure that all staff receives compliance training upon hire and annually.

a. Training and education are key components of the Compliance Program. Training ensures the Laguna Honda workforce and governing bodies receive information about the Compliance Program when they begin employment and at least annually as “refreshers” that reinforce the culture of compliance.

b. The Compliance Officer is responsible for developing, coordinating and participating in education and training efforts to ensure that staff are knowledgeable about the Compliance Program. Additionally, the Compliance
Officer will recommend that targeted training is provided to specific audiences when warranted due to identified compliance risks.

5. Compliance Standards and Policy and Procedures

Laguna Honda, through its Compliance Officer, shall ensure that Laguna Honda Hospital and Health at Home has developed and distributed written policies and procedures that establish Compliance standards. Policies and procedures are also created and/or updated in response to new laws and regulations that affect the Compliance Program.

a. DPH Code of Conduct: The DPH Code of Conduct applies to Laguna Honda and Health at Home employees and volunteers. The Code of Conduct is provided by Human Resources to new employees at the time of hire with signed acknowledgment. Staff is also required to review with signed acknowledgement annually through the annual compliance training module. Training and education are key components of the Compliance Program.

b. Compliance Program Policies: In addition to adherence to the DPH Compliance Policies, Laguna Honda Hospital and Health at Home maintains specific compliance policies and procedures for issue that may be pertinent on to Laguna Honda campus operations.

i. Departments within the Laguna Honda campus shall also maintain their own department-specific policies and procedures for ensuring proper controls and monitoring of activities that impact billing and reimbursement such as documentation of medical necessity, selection of procedure (CPT) and diagnosis (ICD-9/10) codes, accuracy of data submitted to government agencies for claims reimbursement, etc.

6. Reporting Compliance Issues

a. Laguna Honda, through its Compliance Officer, shall make lines of communication available for employees to report fraud and compliance concerns with the option of remaining anonymous. This includes a confidential Compliance Hotline at 415-642-5790.

b. Laguna Honda Hospital and Health at Home also maintains a strict non-retaliation policy for employees who report compliance violations. Staff is expected to report concerns by first discussing with their supervisor or manager, then through the Compliance Hotline, or by contacting the Compliance Officer directly at 415-759-4072 or interoffice mail: Laguna Honda Compliance Office, Administration Building.

7. Investigating Compliance Issues
Laguna Honda, through its Compliance Officer, shall promptly investigate reports of violations of the Compliance Program or federal or state laws and regulations related to billing for health care services.

Laguna Honda Hospital and Health at Home senior management shall implement corrective measures up to and including dismissal for employees who are out of compliance with the Compliance Program or any federal or state law related to billing for health care services.

8. Auditing and Monitoring Activities

Laguna Honda, through its Compliance Officer, shall conduct periodic auditing and monitoring of potential risk areas.

a. The Compliance Officer monitors and coordinates responses to external billing audit requests to ensure that documentation is submitted timely in accordance with the various auditors’ timelines and protocols, and corrective steps are taken as necessary in response to audit denials.

b. Laguna Honda, through its Compliance Officer, also conducts monitoring and auditing activities to proactively ensure on-going compliance with federal and state regulations and guidelines related to billing and reimbursement for healthcare services. An internal monitoring plan is developed as part of the annual compliance work plan and includes areas of potential risk that have been identified through the bi-annual risk assessment.

c. Any findings of improper billing identified through the internal monitoring process will result in prompt refunds to the payer, an assessment of the root cause resulting in the findings, and corrective actions to be taken to resolve the matter.

d. The Compliance Officer monitors corrective actions to ensure that improvements are sustained.

1. Laguna Honda is committed to comply with all applicable federal and state statutes and regulations related to billing for services. To this end, it maintains a Compliance Program with the following structure:

a. The commitment of leadership and the allocation of resources for compliance activities including, but not limited to, the following:

i. Appointment of a Compliance Officer who has oversight responsibility for the Compliance Program;

ii. A Compliance Committee that meets at least quarterly to review and conduct compliance activities. This committee shall consist of the Compliance Officer as Chair, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Quality Director, Deputy City Attorney, and designated staff from Patient Financial Services, Health Information Systems, and Utilization Management. Other staff may be appointed to the committee or invited to committee meetings as deemed necessary by the Chair.
iii. The Compliance Officer shall provide oversight of compliance activities conducted and present findings at the quarterly committee meetings.

iv. The committee shall periodically reassess the Compliance Program to identify necessary changes due to findings from compliance activities, changes in business practices or processes, and new regulations and risks.

v. A Compliance report shall be presented to the Governing Body, through the Laguna Honda Joint Conference Committee, on an annual basis.

b. Laguna Honda, through its Compliance Officer, shall ensure that all staff receive compliance training upon hire and annually.

c. Laguna Honda, through its Compliance Officer, shall make lines of communication available for employees to report fraud and compliance concerns with the option of remaining anonymous. This includes a confidential Compliance Hotline at 415-642-5790. Laguna Honda also maintains a strict non-retaliation policy for employees who report compliance violations.

d. Laguna Honda, through its Compliance Officer, shall promptly investigate reports of violations of the Compliance Program or federal or state laws and regulations related to billing for health care services.

e. Laguna Honda shall implement corrective measures up to and including dismissal for employees who are out of compliance with the Compliance Program or any federal or state law related to billing for health care services.

f. Laguna Honda, through its Compliance Officer, shall conduct periodic auditing of potential risk areas.

ATTACHMENT:

None

REFERENCE:

DPH Compliance Program
DPH Compliance Program – Relevant Federal and State Compliance Related Statutes and Regulations
DPH Compliance Policy – Operation of a Compliance Program
DPH Compliance Program Code of Conduct
DPH Compliance Program – Employee Compliance Hotline
DPH Compliance Program – Employee Non-Retaliation Policy
DPH Compliance Program – Guide to Government Interviews and Investigations
Section 6102 of the Affordable Care Act

Revised: N/A 15/05/12 (Year/Month/Day)
Original adoption: 13/03/26 (Year/Month/Day)
DISCHARGE PLANNING

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, Laguna Honda continually facilitates timely and safe resident discharges to the appropriate level of care.

POLICY:

1. Laguna Honda strives to assist every client/resident (hereafter “resident”) achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the care team shall continue to support maximal social integration.

2. The facility provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences.

3. Residents who no longer meet skilled nursing facility (SNF) level of care and/or who SNF needs can be met a lower level of care shall be prepared for discharge into the community with supportive services.

4. Intensive discharge planning support and skills training shall be provided to the resident to assist him or her to transition from an institutional setting to community living.

5. The Resident Care Team (RCT) shall recognize that residents with decision-making capacity and or their surrogate decision-maker (SDM) have the right to decline recommended discharge options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge plan.

6. Residents with decision making capacity who repeatedly decline discharge options, or refuse to participate in discharge planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT.

PURPOSE:

To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer needs SNF services or are able to be cared for at a lower level of care.
PROCESS DEFINITION AND GUIDELINE:

1. Discharge assessment process considers:
   
   a. The resident’s characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).

   b. The resident’s values and preferences.
      
      i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.

      ii. The resident’s self-assessment of needs and priorities may legitimately differ from that of the RCT.

2. Discharge planning:
   
   a. Begins during the resident's admission assessment.

   b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.

      i. A resident may need to progress through several stages of increasing independence prior to discharge.

      ii. Certain residents may be expected to leave Laguna Honda and return, perhaps repeatedly.

      iii. The experience of residents who have been at a lower level of care for one or more limited periods can lead to valuable refinements of the discharge plan.

   c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.

      i. Informed choice is a fundamental principle of service delivery.

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1 Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single ‘appropriate’ setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers.” (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).
ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

iii. Residents, SDMs, caregivers, and RCT members may enlist the Ethics Committee, ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. Utilization issues:

a. Resident independence and resource stewardship are Laguna Honda Hospital and Rehabilitation Center values that inform discharge planning.

i. Residents shall be discharged to the lowest possible levels of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, self-care readiness, and a sense of hope for future possibilities.

4. Conservatorship and decisional capacity:

a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

b. Absent legal adjudication, the primary physician bears responsibility for determining if a resident has capacity to make informed choices about interventions and discharge planning.

i. A resident may have only partial or varying capacity to make informed decisions.

ii. Capacity determination for residents with mild-moderate impairments is a clinical art about which good clinicians may responsibly disagree.

iii. The conservatorship process may be helpful in resolving disputes and protecting residents.

b. A resident with capacity retains the right to make decisions that RCT members consider unwise.
i. RCT members shall educate the resident (or conservator or other SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining his/her well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall nevertheless elicit, document, and consider the resident’s current and/or past values and preferences relevant to discharge.

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

a. Laguna Honda is committed to developing collaborative relationships with other organizations in order to meet residents’ needs.

b. RCT members should be familiar with community-based services appropriate to their disciplines.

c. RCT members should seek positive collaborations with members of the resident’s informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.

PROCEDURE:

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner when the resident’s condition improves and s/he no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. The resident and or their SDM shall be educated on admission by designated members of the RCT that when their health condition sufficiently improves or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be finalized to transition the resident back to the community.

3. All discharges, with the exception of rehab service residents whose stay is less than 90 days, are planned in advance with the collaboration of the Diversion Community Integration Program (DCIP) and wrap-around community services secured prior to the resident’s discharge.
3.4. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Social Services Director or designee, the Utilization Management Manager or designee, the Medical Director or designee, and Chief Nursing Officer or designee shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

4.5. RCT Roles and Responsibilities

The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

a. RCT Responsibilities

i. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, Occupational Therapist, Physical Therapist, or Speech Therapist with others as needed:

ii.i. Perform the discharge assessment process as described and negotiate the discharge plan.

iii.ii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.

iv iii. Encourage the resident to sustain healthy relationships and interests in the community.

v. iv. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.

v. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.

vi. Identify need for evaluation of resident’s baseline function in regard to ADLs, IADL, or mobility that require rehabilitative services to assess readiness for discharge.

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2 The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.
vii. Document the resident's (and/or surrogate's) understanding of the discharge plan.

viii. Complete the appropriate sections of the Post-Discharge Plan of Care form.

b. Physician

i. Addresses the resident’s preliminary rehabilitation and discharge potential in the admission History & Physical.

ii. Communicates with the resident (or surrogate), caregivers, and with RCT members regarding the resident’s conditions and expected course so that the goals of care can be adjusted as needed.

iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.

iv. Attempts to simplify the resident’s medication regimen, preferably months or weeks prior to discharge.

v. Ensures that appropriate post-discharge medical follow-up is arranged.

vi. Writes discharge order.

c. Social Worker / Targeted Case Manager (TCM)

i. Coordinates the discharge assessment process and plan.

ii. Contacts the resident’s caregivers and community-based support services to inform them of the admission, to invite them to care conferences, and to seek their collaboration.

iii. Attempts to secure the resident’s housing if discharge is possible.

iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.

v. Completes the discharge assessment instrument (MR 711), describing the resident’s needs, supports, barriers to discharge, and team recommendations. (Laguna Honda social worker only).

vi. Enters into the Laguna Honda discharge database any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.
vii. Updates the discharge assessment as needed due to pertinent changes or upon readmission to Laguna Honda.

viii. If discharge is not currently a viable option and is not included in the formal care plan, documents the reasons.

ix. Identifies differences of opinion among RCT members in regard to the resident’s discharge and encourages open discussions based upon professional assessments.

x. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

xi. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.

xii. Makes additional referrals as needed prior to discharge.

xiii. Gives a copy of Discusses the post-discharge plan to with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

xiv. Prepares and provides the resident with a preliminary copy of the Post-Discharge Plan of Care when the resident is issued a Notice of Proposed Transfer/Discharge.

xv. Completes the appropriate section of Reviews, updates the plan as necessary and provides the resident with a revised copy of the Post-Discharge Plan of Care form (MR 705) just prior to the resident’s discharge from the facility.

xvi. Documents discharge planning efforts and resident preparation and orientation to the discharge plan to ensure a safe and orderly discharge from the facility.

xv. Coordinates referral process to Diversion Community Integration Program (DCIP) for review prior to discharge.

d. Nurse

i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the plan of care. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.
iii. Arranges for discharge supplies as needed.

iv. Arranges pre-discharge pharmacy consultation for medication education.

v. Coordinates completion of the Post-Discharge Plan of Care form, including resident or surrogate signature, and provides a copy to the resident or surrogate.

e. Activity Therapist

i. Assesses and documents the resident's pre-admission interests.

ii. Promotes maintenance/enhancement of IADLs through activities.

iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.

iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.

f. Rehabilitation Specialist (occupational, physical, speech therapy) upon receipt of referral from physician: Performs evaluation of resident's overall functioning including basic activities of daily living, instrumental activities of daily living, community re-integration, recommendations and training for use of Durable Medical Equipment, recommendations for continued therapy and support services at the appropriate level of care post-discharge.

g. Other Disciplines / Services

In addition to the RCT responsibilities noted above

iv.i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the Post-Discharge Plan of Care form.

v. Occupational therapist / Physical therapist performs community re-entry skills assessments as needed and arranges for durable medical equipment.

vi.ii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborate with the social worker on enteral feeding supplies.

vii.iii. Utilization management staff provides focused studies of the quality of discharge planning and documentation.
Vocational Rehabilitation, the PREP (People Realizing Employment Potential Coordinator) meets with interested residents about pre-vocational options, training, and community resources.

Peer Mentors provide emotional and practical support to residents transitioning into the community.

### Notification of Resident Regarding Discharge From Facility

a. The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident’s medical record. A resident or surrogate is entitled to written 30-day notification except under the following conditions:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

iii. Improvement in medical condition requiring a lower level of care.

iv. The health or safety of individuals in the facility is endangered.

v. Resident has resided in the facility less than 30 days.

b. Written notice (MR 707) to the resident or surrogate shall include:

i. Reasons for discharge.

ii. Date the discharge will occur.

iii. Discharge destination.

iv. Name, address, and phone number of the State ombudsman.

v. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

vi. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
vii. Resident’s right to appeal to the California State Department of Health Services.

viii. Resident’s right to request a seven-day bed hold.

c. Residents may choose to waive their notice period if they wish to be discharged prior to the conclusion of the notice period.

d. If the resident or SDM is opposed to discharge, s/he will be encouraged to discuss it with the RCT and ombudsman.

i. The social worker or nurse manager will alert the Medical Director, Chief Nursing Officer or designee, Director of Quality Management, and Executive Administrator (or their designee) prior to issuance of the written notification of discharge.

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

6.7. Involuntary Discharges

a. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. Legal counsel shall be consulted in circumstances when the resident and or SDM refuses to participate in discharge planning efforts (e.g. refuses to sign release of information forms or complete housing applications, etc.).

b. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with a minimum of two housing options that the RCT considers to be the best viable discharge option available in the community.

c. Refer to LHHPP File 20-05 Discharge Appeal Process when the resident verbalizes that s/he disagrees with the plan to be discharged to the community and refuses reasonable placement options.

7.8. Residents Leaving Against Medical Advice (AMA)

a. When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.

b. If the resident is conserved or does not understand the nature and consequences of a decision to leave Laguna Honda without permission, the physician will immediately attempt to contact the surrogate.
c. If leaving Laguna Honda would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.

d. If the consultant deems the resident a danger to self or others due to mental illness, he or she will initiate a psychiatric hold and transfer the resident to acute care.

e. The nurse or physician will present the form MR 804, “Request to Leave the Hospital Against Medical Advice” to the resident (or surrogate) in the presence of a witness.
   i. If the resident or surrogate refuses to sign, the nurse or physician will write on the form, “Resident refuses to sign.” Nurse/physician and witness will sign.

f. The nurse or physician will complete an Unusual Occurrence form.

g. When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.

**DEFINITION:**

1. ADLs and IADLs: Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:

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<tr>
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<th>IADLs</th>
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<td>Dressing</td>
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<td>Eating</td>
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<td>Ambulating</td>
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<td>Hygiene</td>
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2. Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.
3. Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).

ATTACHMENT:
Attachment A: Substance Abuse and Dual Diagnosis Treatment Placement for LHH Patients
Attachment B: LHH SATS Referral Protocol for Opiate Replacement Treatment

REFERENCE:
LHHPP 20-05 Discharge Appeal Process
LHHPP 20-06 Pass Policy
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Development and Implementation of an Interdisciplinary Resident Care Plan
NPP C1.0 Admission, Relocation and Discharge Procedures
AGAINST MEDICAL ADVICE

POLICIES:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) supports the rights of residents to:
   a. make decisions regarding their medical care
   b. request or refuse treatment, to the extent permitted by law
   c. leave the hospital against the advice of physicians, to the extent permitted by law

2. Laguna Honda determines that a resident with decisional capacity, who has been provided, acknowledged receipt and agrees to abide by the requirements of the AMA and Pass Policy as going against medical advice (AMA) if s/he leaves Laguna Honda without notification or without an approved leave of absence (AWOL) past midnight.

PURPOSE:

To comply with State and Federal regulations pertaining to Resident’s Rights and the medical necessity criteria for continued stays of residents in Skilled Nursing Facilities.

DEFINITIONS:

1. Against Medical Advice (AMA): A resident is discharged AMA when he/she chooses to leave Laguna Honda Hospital against the advice of the physician.

2. Absent Without Leave (AWOL): A resident who leaves Laguna Honda Hospital and Rehabilitation Center without notification or without an approved leave of absence.

3. Leave of Absence/Out on Pass Bed Hold: A planned absence of a resident from Laguna Honda Hospital authorized by a physician’s order, which extends past midnight.

PROCEDURES:

1. Laguna Honda Admissions and Eligibility shall provide each newly admitted resident/surrogate decision maker with a copy of the Laguna Honda AMA and Pass Policy.

2. The resident or surrogate decision maker acknowledges receipt of the policies and agrees to abide by its requirements by their signature on all required documents in the Admissions packet.
3. The physician will assess the resident’s ability to understand the risks of leaving the hospital without permission and the resident’s conservatorship status. Based on this information, the physician will determine whether the resident should be considered “Absent Without Leave” (AWOL) or “Missing Cognitively Incapacitated” (MCI) if the resident were to leave the hospital without a physician’s order. When a resident expresses the desire to leave AMA, the physician will assess the resident’s cognitive capacity and ability to understand the risks of leaving the hospital and discontinuing medical treatment. Based on this assessment, the physician will determine whether the patient can leave AMA.

4. If the resident is at risk of going AWOL, the physician shall discuss the risks with the resident and document that discussion in the chart and reiterate Laguna Honda’s policy that s/he will be discharged AMA if s/he goes AWOL past midnight. Reassessment and ongoing discussion with the resident may be appropriate.

5. If clinically appropriate, the attending physician or designee shall complete a Pass Order form for the resident who wishes to go on a therapeutic leave off the grounds of Laguna Honda.

6. The Resident Care Team (RCT) shall develop a discharge plan at the time of the resident’s admission or as soon after admission as feasible if the resident is assessed to be at risk of going AWOL.

7. If the resident chooses to leave Laguna Honda and goes against medical advice, or goes AWOL past midnight:
   4.
   a. The resident is considered AMA and will be discharged.
   b. If possible, the resident should also sign the AMA form where indicated.
   c. Physician writes AMA discharge order.
   d. The RCT gives the resident a list of emergency shelters, food sources, medical and medication referrals if there was sufficient advance notice of the resident’s intentions and completes the corresponding documentation.
   e. The resident is considered AMA and will be discharged.
   f. Laguna Honda Hospital and Rehabilitation Center will not hold the resident’s bed.
REFERENCES:
LHHPP 20-02 Bed Holds
LHHPP 20-04 Discharge Planning
LHHPP 20-06 Pass Policy
MR 804

Revised: N/A 05/12 (Year/Month/Day)
Original adoption: 09/03/02
SAFE MEDICATION ORDERS

PURPOSE:
To ensure resident safety by reducing the potential for error or misinterpretation when orders are communicated.

POLICY:
Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal communication of prescription or medication orders is limited to situations in which immediate written communication is not feasible. Medication orders from physicians, dentists, podiatrists, physician assistants, nurse practitioners, and pharmacists are accepted if they comply with the requirements listed below.

PERSONS AFFECTED:
Clinical Staff, including but not limited to Physicians, Nurses and Pharmacists

FUTURE ISSUES:
1. 2009: Expected transition to new hospital
2. Changeover to electronic medical record

PROCEDURE:
1. Medication Orders:
   a. All prescription orders must be in writing or electronic and should contain the following:
      i. Date and time order is written
      ii. Patient name and medical record number
      iii. Medication name (generic preferred)
      iv. Strength or concentration
      v. Dose
      vi. Frequency or time of administration of the medication
      vii. Route, e.g. PO, IM, SC, IV or rectal
      viii. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.
      ix. Duration of therapy or quantity if applicable (e.g. antibiotics, outpatient prescriptions, pass medications)
      x. Prescribing practitioner signature
b. Medication orders that have a Banned abbreviation (e.g. QD instead of daily), acronym or symbol may not be used in any hand-written, patient-specific communication. This includes medication and treatment orders, medication and treatment administration records, laboratory and radiology orders, progress notes, etc. See appendix A (Do not use abbreviation list).

c. All verbal or telephone orders to the nurse should be immediately recorded in the resident's chart and signed by the prescriber within 48 hours for the acute units and within five days for SNF units.

d. Orders that are incomplete, illegible or unclear will not be transcribed or processed by nursing or pharmacy. Prescribing practitioner will be contacted for clarification and new order written. Making corrections to an existing order (e.g. crossing over an order) is not permitted.

2. Requirements for specific categories of Medication Orders:

a. "As needed" (PRN) orders: Must include dose, frequency, route and indication for use.

b. There will be no standing orders for medications or treatments. Standing Orders are defined as orders that allow practitioners to automatically & globally implement patient care without a patient specific order.

c. Hold orders: A "hold order" is interpreted as "discontinue" unless it is specified with specific parameters (e.g. Hold if PT-HR < 60> 25). A hold order with specific parameters is held until the next scheduled dose.

d. Automatic stop orders: Drugs not specifically prescribed as to time or number of doses must automatically be stopped as outlined in the Policy and Procedure for Automatic Stop Orders (PHARM 01.02.02).

e. Resume, Renew, Continue orders: Blanket reinstatement of previous medication orders is not acceptable. Resume, renew or continue orders must be written as a new order with all specified elements for a medication order as defined by this policy and procedure.

f. Titration orders (orders that a medication is to either progressively be increased or decreased for a specific patient response): "Titration orders" must contain criteria for use and clear parameters as to when to increase or decrease the medication.

g. Taper orders: "Taper orders" refer to those in which the dose is decreased by a particular amount with each dosing interval. Each dose of a tapering regimen must be clearly written out.
h. Range Orders: There will be no range orders for medications. "Range orders" are defined as those in which the dose or dosing interval varies over a prescribed range. (e.g. instead of Oxycodone 5-10mg PO Q4 hours prn pain prescribe Oxycodone 5mg PO Q4 hours PRN mild pain; Oxycodone 10mg PO Q4h PRN moderate pain).

i. Multiple PRN medications written for the same indication: The parameters for use of each medication must be clearly written to specify when it should be used (e.g. Milk of Magnesia 30ml PO daily PRN constipation; Bisacodyl 10mg PR daily PRN constipation not relieved by MOM).

j. Medications written with multiple routes of administration: The parameters for use must be specified (e.g. Famotidine 20mg PO Q12h, give IV if resident unable to take PO).

k. Investigational medication orders: Refer to PHARM 02.05.00 on Investigational Drugs.

3. Verbal Orders:

a. Communication of prescription or medication orders is limited to situations in which immediate written communication is not feasible. Verbal orders, when indicated, will be immediately written down by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be written before it is read back. The resident's allergy status must be discussed. Refer to LHHPP 25-03 Verbal Telephone Medication Orders.

4. STAT Orders & Pharmacy Response Time:

a. Nursing service and pharmacy (when open) shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. When the pharmacy is closed, drugs ordered STAT which are available in the emergency drug supply shall be administered immediately. The nursing supervisor will be notified when access to the supplemental medication room or the on call pharmacist is needed as outlined in the P&P for Emergency and Supplemental Medication Supplies (PHARM 02.03.00).

b. Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

c. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

d. Refills shall be available when needed.
5. Discontinued Medication Orders:

   a. By the end of shift during which the medication is discontinued, the nursing unit will send or fax the order to Pharmacy, print "DC" on the prescription label. Room temperature medications are placed in the drug pick-up box. Unopened, refrigerated medications are returned to the pharmacy immediately. This also applies to the medications of residents who expire. The pharmacy will process discontinued orders within 4 hours of receiving.

ATTACHMENT:
None

REFERENCES:
Automatic Stop Order Policy, PHAR 01.02.02
Do Not Use Abbreviation List
Emergency and Supplemental Medication Supplies, PHAR 02.03.00
Investigational Drugs Policy, PHAR 02.05.00
Verbal Order Policy, LHHPP 25-03

Revised: 08/02/12, 15/05/12 (Year/Month/Day)
Original adoption: 07/10/20
VERBAL/TELEPHONE ORDERS

POLICY:

1. Verbal communication of prescription or medication orders is limited to situations in which immediate written communication is not feasible.

2. Verbal orders are not indicated when the prescriber is present and the patient's chart is available, except in an emergency situation, in which case a repeat-back is acceptable.

3. Verbal orders are not permitted for chemotherapy.

4. The following job categories are authorized to give verbal orders:
   a. Physician
   b. Affiliated Healthcare Practitioners credentialed by the medical staff
   c. Advanced Practice Nurse credentialed by Medical Staff
   d. Dentist
   e. Podiatrist

5. The following job categories are authorized to accept verbal orders:
   a. Licensed nurse (RN, LVN, LPT)
   b. Licensed pharmacist
   c. Licensed rehabilitation therapist (physical therapy, occupational therapy, speech therapy)
   d. Respiratory therapist
   e. Clinical dietitian

6. Staff giving or accepting verbal orders are limited to only those orders within their scope of practice.

PURPOSE:

To reduce errors associated with misinterpreted verbal or telephone communications of physician orders.

PROCEDURE:

1. Verbal orders, when indicated, will be immediately written documented in the electronic health record or written down by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be written documented before it is read back.
2. The recipient will record each verbal order directly into the electronic health record or onto an order sheet in the patient's chart and will include phone or pager numbers in case it is necessary for follow-up questions.

3. The prescriber and person accepting the verbal order will discuss the resident's allergy history when the order is for a medication.

4. Both parties will pronounce numerical digits separately—saying, for example, "one six" instead of "sixteen."

5. For medication orders, the prescriber will spell the name of any unfamiliar medication, if either party feels this is necessary.

6. Prescribers will include the purpose of the drug to ensure that the order makes sense in the context of the patient's condition.

7. Both parties will express doses of medications by unit of weight (e.g., mg, g, mEq, mMol).

8. Recipients of verbal orders will sign, date, time, and note the order at the time it is written on the order sheet. The electronic health record will time stamp the order.

9. The prescriber will verify, sign, and date orders within 48 hours for the acute ward and within 5 days for SNF wards. Another physician may not verify and sign for the prescriber.

10. Verbal orders, when spoken and when transcribed, will use only approved abbreviations. (e.g. "daily" written instead of QD, refer to do not use abbreviation list).

11. Verbal medication orders will include the following information:
   
   a. Date and time order is received
   b. Patient name
   c. Drug name (brand or generic)
   d. Strength or concentration
   e. Dose
   f. Frequency or time of administration of the medication
   g. Route if other than oral, e.g. IM, SC, IV or rectal
   h. All "PRN" orders must include the indication for use of the medication and how often prn medications may be given.
   i. Duration of therapy or quantity
   j. Name of prescriber
   k. Signature of order recipient
ATTACHMENT:
None

REFERENCE:
Nursing Policy and Procedure C 9.0 Transcription and Processing of Orders


Revised: 08/02/12, 10/11/24, 11/03/24, 12/07/31, 14/05/27, 15/05/12 (Year/Month/Day)
Original adoption: 06/12/22
GUIDELINES FOR SALES, DISTRIBUTION OF FREE ITEMS, AND SOLICITATION ON THE CAMPUS

POLICY:

1. Sales, distribution of free items, and solicitation on the Laguna Honda campus must be consistent with the mission, vision, values, and strategic goals of the hospital.

2. Laguna Honda staff and/or volunteers shall not be responsible for communicating information (either written or oral) on behalf of vendor(s) to campus members.

PURPOSE:

To preserve the residents’ safety and health and to ensure that resident care remains the primary focus of the workplace.

PROCEDURES:

1. Approval Process
   a. Individuals or organizations wishing to sell items, solicit memberships, or distribute free merchandise must submit a request form to the Administration Office for review by designated member(s) of the Hospital Executive Committee. Requests must conform to the guidelines in Sections 2–6 below.

2. Free Merchandise
   a. No vendors, solicitors, or distributors of free merchandise are authorized to be on the Laguna Honda campus unless they:
      i. Have approval from the Hospital Executive Committee, and
      ii. Provide products or services that are consistent with the mission, vision, values, and strategic goals of the hospital.

3. Merchandise for Sale
   a. No person(s) or organization may sell or distribute items to residents or staff without first obtaining authorization of the Hospital Executive Committee/designee.
      i. This prohibition is applicable during rest breaks as well as meal breaks taken anywhere on hospital premises.
      ii. Businesses wishing to sell goods or services at Laguna Honda must provide a copy of Seller’s Permit to do business in San Francisco. The permit is due at the same time as the Application for Use of Laguna Honda Campus is completed.
ii. All on-premises transactions involving the transfer of money or goods are covered by this prohibition, whether or not the parties enjoy formal commercial vendor status.

4. Solicitations
   a. No person or organization may solicit residents for membership, donations, business, or for any other purpose without authorization from the hospital executive committee.
      i. Religious organizations must register with the hospital Spiritual Care Director.
      ii. All other organizations must receive approval from the Hospital Executive Committee.

5. Illegal and Harmful Items
   a. Sales or exchanges involving substances—such as alcohol, cigarettes, weapons, and illegal items and substances—that are contraindicated by the resident’s care plan, interfere with the operation of the hospital, or endanger the lives of staff and other residents are prohibited.

6. Exceptions
   a. Not-for-profit corporations with educational or charity status are exempted as follows:
      i. Nothing in this policy is intended to prohibit sales by residents to other residents or staff of small dollar items such as raffle or other event tickets to benefit legitimate not-for-profit organizations that maintain formal charity or educational status under the law.
      ii. Nothing in this policy is intended to prohibit sales by employees to other employees of small dollar items such as raffle or other event tickets to benefit legitimate not-for-profit organizations that maintain formal charity or educational status under the law, so long as such sales take place during regular break times or mealtime and not while the employee is at his or her work post.
   b. This policy is not intended to prohibit regular sales by residents to residents or staff of miscellaneous small dollar items if authorized by the Hospital Executive Committee. Examples are newspapers and minor creative works by residents.
   c. This policy is not intended to restrict a resident’s right to access to legal products.
   d. Commercial vendors to hospital departments that have contracted to deliver products shall be considered by virtue of the sales contract to have authorization.
7. Violations
   a. Violation of this policy by a resident shall be treated as a patient care issue and referred to the resident care team for appropriate care planning.
   b. Violation of this policy by an employee shall be referred to the employee's department manager for appropriate action.
   c. Violation of this policy by a commercial vendor or solicitor shall be referred to the Operations Division for action.

ATTACHMENT:
   Part A: Application for Use of Laguna Honda Campus
   Part B: Invoice for Use of Laguna Honda Campus

REFERENCE:
   LHHPP 35-05 Guidelines for Medical Service Representatives
   LHHPP 75-02 Public Access and Night Security
   LHHPP 76-02 Smoking Control
   LHHPP 90-08 Campus Use for Non-Laguna Honda Groups
   Form: Application for Use of Laguna Honda Campus Sales, Solicitation of Memberships, and Distribution of Free Items
   Civil Service Rule 118: Outside Employment
   Department of Public Health Statement of Incompatible Activities:

Revised: 92/05/20, 10/03/09, 11/05/13, 15/05/12 (Year/Month/Day)
Original adoption: 92/05/20
### Part A: Application for Use of Laguna Honda Campus

**For Meetings, Events, Filming, Sales, Distribution of Free Items, or Solicitation of Memberships**

This section to be completed by organizational representative or Laguna Honda staff coordinating the event.

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**Laguna Honda Sponsor or Administrative Assistant** (responsible for managing and coordinating the event)

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**Requested Date(s) and Times(s). Specify beginning and ending times.**

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**Requested Location at Laguna Honda**

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</thead>
</table>

**Describe Purpose of Activity** (Include target audience and relationship to any Laguna Honda program)

- Yes, I’m selling goods or services at Laguna Honda. Attached is my Seller’s Permit for SF.
- No, I’m not selling goods or services at Laguna Honda

**Organization Name**

<table>
<thead>
<tr>
<th>Organization Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Public Health</td>
</tr>
<tr>
<td>City and County of San Francisco Agency</td>
</tr>
<tr>
<td>Community-Based or Non-Profit</td>
</tr>
<tr>
<td>Private Sector Organization or Business</td>
</tr>
<tr>
<td>Film/Production Company</td>
</tr>
<tr>
<td>Other. Please describe: ____________________________</td>
</tr>
</tbody>
</table>

**Function or Purpose of Organization**

**Primary Contact:**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Position in Organization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
</tr>
</thead>
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<table>
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</table>

Please Note: Laguna Honda is a non-smoking campus
**TERMS**

(identify organization) shall indemnify and hold harmless the City and County of San Francisco (CCSF) from and against any and all loss, damage, injury, liability, and claims for injury to or death of a person regardless of the negligence of CCSF, and regardless of whether liability without fault is imposed or sought to be imposed on CCSF, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this agreement, and except where such loss, damage, injury, liability, or claim is the result of active negligence or willful misconduct of CCSF and/or is not contributed to by any act of, or by any omission to perform some duty imposed by laws or contract on named organization, its agent or employees.

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<th>Organizational Representative</th>
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</tr>
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<tbody>
<tr>
<td>Signature or E-Signature</td>
<td></td>
</tr>
<tr>
<td>Print Name</td>
<td>Date</td>
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**Administrative Approval**

This section to be filled out by hospital administrative staff

<table>
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<tr>
<th>Housekeeping, Facilities and Security Needs:</th>
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</thead>
</table>

Included with application are:  
- [ ] Part B: Invoice  
- [ ] Sellers Permit  
- [ ] W-9 Tax ID Forms

<table>
<thead>
<tr>
<th>Sponsor/Administrative Assistant Signature:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Facilities Director Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Environmental Director Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Sheriff Signature</td>
<td>Date:</td>
</tr>
<tr>
<td>Chief Operating Officer Signature:</td>
<td>Date:</td>
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<tr>
<td>Chief Financial Officer Signature:</td>
<td>Date:</td>
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<td>Executive Administrator Signature:</td>
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Laguna Honda Hospital and Rehabilitation Center  
375 Laguna Honda Blvd. • San Francisco, CA 94116 • (415) 759-2300 • www.lagunahonda.org

Rev: 2/24/15
### Part B: Invoice for Use of Laguna Honda Campus

For Meetings, Events, Filming, Sales, Distribution of Free Items, or Solicitation of Memberships

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<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>Security</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Security (off hours event and/or large event)</td>
<td>$50</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>$</td>
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Please make checks out to “Laguna Honda Hospital and Rehabilitation Center” and reference the event. Payment must be in advance of the event.

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LAGUNA HONDA CAMPUS USE POLICY FOR OUTSIDENON-LAGUNA HONDA GROUPSMEETING AND EVENT RESERVATIONS BY COMMUNITY GROUPS

POLICY:

1. The Laguna Honda campus is a resource for educational, cultural, civic, and recreational activities in keeping with the mission and strategic goals of the hospital.

2. Persons or organizations applying for use of meeting or event space at Laguna Honda must comply with the Americans with Disabilities Act, City policies, and Laguna Honda Campus use policy, city non-discrimination policies.

2.3. Any Laguna Honda staff may be a sponsor of a non-Laguna Honda group/event.

PURPOSE:

To provide a systematic process for application and use of the Laguna Honda campus for meetings and events, support the use of the Laguna Honda campus as a center of civic activities that promote community integration for Laguna Honda residents.

PROCEDURE:

1. An application to be reviewed by designated members of the Executive Committee/designee must be filed at least two weeks prior to the event. Reservations are not confirmed until the application has been signed by the Executive Administrator/designee.

2. Applicants requesting use of the campus must work with a Laguna Honda employee sponsor event Logistics Coordinator sponsor on the Laguna Honda staff who will manage the application process and coordinate event needs. The sponsoring staff member does not need to be present during the event. If there is no employee sponsor, the applicant will work with a Laguna Honda administrative assistant.

2.--

3. Approval:
   a. The hospital Executive Committee will have the final determination if of whether event requests are consistent with the mission of the organization and the well-being of residents.
   b. In the event of conflicting requests, priority of use will be given as follows:
      i. First priority will be given to hospital-sponsored activities and meetings.
ii. Second priority will be given to other branches of the Department of Public Health and other city agencies.

iii. Third priority will be given to non-profit, community-based, or private sector organizations.

c. The hospital reserves the right to cancel an event at any time for any reason.

4. Orientation Use of Laguna Honda:

   a. An on-site orientation by Facilities, Environmental Services and/or Communications Administration staff about building use, security and maintenance is required for the contact person from groups using the campus for the first time.

   b. The contact person from the group using the campus must be present throughout the event.

   b-c. Fixtures and equipment cannot be altered without the express approval from the Executive Administrator or the Chief Operating Officer. Any destruction or alteration of the premise, equipment, furniture or other hospital property will result in charge(s) in any and all remedial actions taken for correction(s).

5. Fees: Individuals and organizations must pay a daily flat fee of $100.00 for a standard facility usage set-up and cleaning.

   a. The fees may be waived or reduced for government agencies, non-profit organizations and entities providing resident services.

   b. The filming fees charge will be no less than those recommended by the San Francisco Film Commission.

   c. Meetings and events that require a commitment of Laguna Honda resources greater than $100.00 may be subject to higher fees.

   d. A W-9 form, Request for Taxpayer Identification Number and Certification, may be required for meetings and events that require a large commitment of Laguna Honda resources.

   b-e. Businesses wishing to sell goods or services at Laguna Honda must provide a copy of Seller’s Permit to do business in San Francisco. The permit is due at the same time as the Application for Use of Laguna Honda Campus is completed.

   c-f. Organizations may be required to supply their own housekeeping and security personnel.

   d-g. Fees are deposited into the hospital’s operating budget.

   e-h. Payment must be made in advance of the event.

ATTACHMENT:

Meeting Rooms Information and Pictures
Part A: Application for Use of Laguna Honda Campus
Part B: Invoice for Use of Laguna Honda Campus

REFERENCE:

1. LHHPP 01-07, Posting Notices, Hanging Artwork and Caring for the Buildings
2. Laguna Honda Special Events, Filming and Photography Use Agreement (Rider to Film Commission Use Agreement)

2.3. LHHPP 35-01 Sales, Distribution of Free Items, and Solicitation on the Campus

Most recent review: 12/08/29
Revised: 11/09/27
Original adoption: 02/05/20
### Meeting Rooms Information and Pictures: Use of Laguna Honda Campus

For Meetings, Events, Filming, Sales, Distribution of Free Items, or Solicitation of Memberships

<table>
<thead>
<tr>
<th>Room</th>
<th>Capacity</th>
<th>Location in Hospital</th>
<th>Equipment available</th>
</tr>
</thead>
<tbody>
<tr>
<td>B 102</td>
<td>35</td>
<td>Administration</td>
<td>• Dry Erase Board (pens not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td>• Tables and chairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Pull down projector screen (projector not included)</td>
</tr>
<tr>
<td>B 104</td>
<td>12</td>
<td>Administration</td>
<td>• Tables and chairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td>• Dry Erase Board (pens not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Regular Phone (local calls and conference calls only)</td>
</tr>
<tr>
<td>A 300</td>
<td>72</td>
<td>Administration</td>
<td>• Tables and chairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td>• Pull down projector screen (projector not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Podium with microphone</td>
</tr>
<tr>
<td>Computer Lab</td>
<td>24</td>
<td>Administration</td>
<td>• 24 computers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td>• Pull down projector screen (projector not included)</td>
</tr>
<tr>
<td>Moran Hall</td>
<td>100</td>
<td>Administration</td>
<td>• Empty room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td></td>
</tr>
<tr>
<td>Gerald Simon Theater</td>
<td>300</td>
<td>Administration</td>
<td>• Empty room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building</td>
<td>• Elevated stage with large white projection screen (projector not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Note: poor acoustics with no sound system</td>
</tr>
<tr>
<td>Conference Room 1</td>
<td>15</td>
<td>Hospital</td>
<td>• Large computer monitor</td>
</tr>
<tr>
<td>(P1218)</td>
<td></td>
<td>Building</td>
<td>• Laptop plug in capability (computer not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Regular Phone (local calls and conference calls only)</td>
</tr>
<tr>
<td>Conference Room 2</td>
<td>12</td>
<td>Hospital</td>
<td>• Large computer monitor</td>
</tr>
<tr>
<td>(P1191)</td>
<td></td>
<td>Building</td>
<td>• Laptop plug in capability (computer not included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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Meeting rooms and equipment based on availability and subject to change. Not all rooms are described above or pictured below.
Meeting Rooms Information and Pictures- Use of Laguna Honda Campus

A 300 - Administration Building

Moran Hall - Administration Building
Meeting Rooms Information and Pictures - Use of Laguna Honda Campus

Gerald Simon Theater - Administration Building

Conference Room 1 – Hospital Building
# Part A: Application for Use of Laguna Honda Campus

**For Meetings, Events, Filming, Sales, Distribution of Free Items, or Solicitation of Memberships**

This section to be completed by organizational representative or Laguna Honda staff coordinating the event.

<table>
<thead>
<tr>
<th>Application Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Laguna Honda Sponsor or Administrative Assistant (responsible for managing and coordinating the event)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Date(s) and Times(s). Specify beginning and ending times.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Location at Laguna Honda</th>
<th>Number of Persons Attending</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Describe Purpose of Activity (Include target audience and relationship to any Laguna Honda program)</th>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Primary Contact:</th>
<th>Secondary Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
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| Environmental Director Signature: | Date: |
| Sheriff Signature: | Date: |
| Chief Operating Officer Signature: | Date: |
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PHYSICIAN NOTIFICATION AND DOCUMENTATION OF CHANGE IN RESIDENT STATUS

POLICY:

1. The Licensed Nurse will notify the physician whenever there is an unanticipated change in resident’s physical, mental, or psychosocial condition indicative of decline resulting from injury, acute medical illness or resulting from progression of chronic medical conditions.

2. The Licensed Nurse will communicate verbally using SBARN* Method of Communication when notifying the physician.

3. Non-urgent clinical issues, such as unsigned orders, expired medications, non-critical medications will be communicated to the primary care physician during regular business hours using clipboard.

4. When the physician arrives to evaluate the resident, the licensed nurse will be available to provide pertinent assessment information and assist as necessary.

5. Nursing and Physician communication will be comprehensive, understandable, and timely. When there is a change in resident condition, the family or surrogate decision maker will be notified.

PURPOSE:

To inform the physician about changes in resident's condition using a standardized communication method so that the resident receives timely and appropriate treatment interventions.

BACKGROUND:

A “significant change” is defined in the RAI/MDS as a decline (or improvement) in a resident’s condition that (a) will not normally resolve itself or is not self-limiting; (b) impacts more than one area of the resident’s health status; and (c) requires interdisciplinary review and/or revision of the resident care plan.

Reportable significant changes for decline or improvement are listed below but not limited to:

1. Significant change in the resident’s physical, mental or psychosocial condition.
2. A significant change or alteration in the treatment or care plan.
3. A decision to transfer or discharge the resident from the facility.
4. Significant change of weight (5 pounds or 5% within 30 days or 10% within the last 180 days).
5. An untoward reaction to medications or treatments.
6. Any life-threatening error in medicine or treatment (any risk to the resident).
7. Any time the facility is unable to timely obtain or administer drugs, equipment, supplies or services as prescribed, under conditions which present a risk to the health, safety or security of the resident.

PROCEDURE:

A. Physician Notification using SBARN* Method of Communication

See attached Appendix A
B. Family/Significant Others Notification

For family notifications regarding a serious incident or change in condition, the licensed nurse and physician will discuss the situation and make a decision regarding which of them should notify family/significant other, taking into account any prior relationship with the family/significant other and the risk management implications (refer to HWLHPP 24-11).

C. Reporting and Documentation

1. Integrated Progress Notes
   a. Chart the date, time and name of the physician who was notified of the change in resident's condition and each subsequent attempt to notify the physician.
   b. Document notification of the Nurse Manager, Nurse Supervisor, or Program Director.

2. Comprehensive MDS Assessment

A Significant Change of resident condition requires that a comprehensive MDS Assessment is completed no later than fourteen (14) days after the determination by the Resident Care Team (RCT) members that a significant change has occurred. After completion of MDS assessment, a special Resident Care Team Conference should be scheduled for RCT discussion.

APPENDIX:

Appendix A: Physician Notification Using SBARN* Method of Communication

REFERENCES:

RAI/MDS Manual
SBAR Tool was developed by Kaiser Permanente
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

CROSS REFERENCE:

LHHPP File # 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
LHHPP 24-24 Nurse-Physician Communication During Quiet Hours 10 PM to 6 AM

HW Policies and Procedures: 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition
HW Policies and Procedures: 23-01 Resident Care Plan, resident Care Team & Resident Care Conference

Reviewed: 05/12/2015
Notification and Documentation of
File: C 4.0 October, 2010 February 13 May 12, 2015, Revised
Physician Notification of Change in Resident Status
Nursing Policies and Procedures

Reviewed by ________ and no revision recommended at this time.

Approved: __________

For Ghe use only:
Date sent to Policy Reviewer __________
Date received from Policy Reviewer __________
Date reviewed by NEC __________
Date approved by NEC __________
Date routed to MEC __________
Date emailed to Karina __________
APPENDIX A

USING SBARN* Method of Communication

A. Before contacting the physician, complete the following:

1. Assess the resident for vital signs, change in mental status, symptoms, and pertinent physical findings.
2. Review the chart/LCR for last progress notes, any recent treatment and medication changes, recent lab results, and advanced directives.
3. Have the resident's medical record and MAR available

B. Use SBARN* Method of Communication:

1. S – SITUATION: What is the problem or concern regarding resident
   a. Identify yourself: state your name, position i.e. job title
   b. Identify the resident: “I am calling about….resident name, age, household room number/bed number…”
   c. Describe the situation you are calling about: “The reason I am calling is…….”

2. B – BACKGROUND: Brief, related to the point
   a. State the admission diagnosis and date of admission
   b. State the pertinent medical history, recent laboratory results pertaining to the current problem
   c. State a brief synopsis of the treatment to date, code status

3. A – ASSESSMENT: What you found and what you think or what is your assessment
   a. Pertinent subjective information gathered from resident, family or nursing caregivers. The chart, MAR, medication allergies and other needed documentation are to be available for easy reference.
   b. Pertinent objective data
      i. Most recent vital signs including quality of respiration or changes in pulse rhythm, pain assessment, skin color
      ii. New or changed medications significant to current status
      iii. Neurological changes: Mental status – new behaviors
      iv. Any interventions taken and their effectiveness

4. R – RECOMMENDATION: State what you would like to see done
   a. Change in treatment? How often?
   b. Diagnostics: Lab/CXR/EKG?
   c. Ask MD: “If resident does not improve, when do you want to be called again?”
5. **N* – NOW**: Urgency of the situation

   a. Is there an urgency for the physician to do further evaluation?
   b. Is there an urgency to transfer resident to the hospital?

**Note**: *N* was added to SBAR by LHH Medical Staff to indicate the urgency of physician evaluation with the N (now)

a. Request physician visit/assessment
b. Change in treatment? How often?
c. Diagnostics: Lab/CXR/EKG?
d. Transfer resident to hospital?
e. Ask MD: “If resident does not improve, when do you want to be called again?”


Reviewed: __________

Approved: __________ 05/27/2014
TUB BATHS AND SHOWERS AND NAIL CARE

POLICY:

1. Licensed Nurse in collaboration with the Nursing Assistant, and if appropriate Rehabilitation Staff, and/or Resident Care Team (RCT) are responsible for assessing, planning, meeting bathing needs, and accommodating preferences of residents. Direct caregiver are to be familiar with the resident's plan of care to determine the type of assistance and the mode of transfer before proceeding to give a tub bath or shower.

2. Bathing includes nail care, hair care, shaving, and cleansing of skin surfaces.

2.3. Bathing alternatives will be offered if resident finds a tub bath or shower distressing or unacceptable.

3.4. A resident who requires assistance shall not be left unattended for safety reasons. Before using lift, review Lift Procedures, and request instruction and assistance, if necessary.

4.5. Nursing staff are responsible for cleaning and disinfecting the shower chair and tub. All care equipment used for bathing are cleaned and disinfected after each resident's use. Resident need and preference will determine the precise frequency, schedule, and manner of bathing. Residents on bed rest receive complete bed baths as needed. Bathing preferences are indicated on the Front Card of the Resident Care Plan (RCP) or are included as a care plan problem as needed.

5. Never leave a resident in tub or shower room unattended.

6. Shampoos are usually given with the first tub bath of the week.

7. Fingernails and toenails are usually cut after the second tub bath or shower while the nails are still soft. When the nail clippers are used for more than one resident, they are to be washed and soaked in the approved germicide.

8. Residents with pressure ulcers, wound or skin infections will be showered after other residents have received their shower.

9. The direct caregiver will coordinate with other Interdisciplinary Team (IDT) members for the use of the tub for his/her residents. The nurse manager/charge nurse in consultation with the resident will schedule days for tub baths, or showers.

PURPOSE:

To meet resident's hygiene needs. To cleanse, refresh, and observe resident's skin and body condition.

PROCEDURE:

A. Equipment

- Soap and/or shampoo
- Comb and/or hair brush
- Personal clothing, including footwear
- Bath towels and washcloths
- Toiletries
Nail clippers and nail brush
EZ-Lift (if needed)

B. A. Preparation

1. Gather all equipment prior to bathing the resident. Check with the team leader to determine whether bandages, if any, are to be removed before the bath is given. Refer to Infection Control Procedures.

2. Check with the Licensed Nurse for any preparation needs. Wash your hands.

C. B. Bathing the Resident using the Tub

1. Use appropriate transfer technique per resident. Check with the RCP page to determine whether bandages, if any, are to be removed before the bath is given. Refer to NPP D 6.1.1 EZ-Lift Transfer when resident requires a lift transfer.

2. Resident has a preference to use a regular tub or portable tub. For guidelines using these tubs, please refer to:
   a. Attachment 1: Operating and Cleaning of Tub (Arjo Parker Tub), or
   b. Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley).

2. Refer to D2 4.0 Operating and Cleaning Jacuzzi Tub. Check that water temperature does not exceed 104 degrees F before resident enters the tub, and have resident test the water for comfort.

3. Refer to NPP D 6.1.1 Battery-Operated Lift Transfer and LHHPP 24-19 The C-625 Battery-Operated Ceiling Lift. Slings used for bathing are labeled per individual resident.

3.4. Follow recommendations for bathing in the RCP. Usually, bathe thoroughly with soap and water starting with face. Omit soap on face if resident so desires. Give special attention to folds in skin, umbilicus, ears, and between toes. Observe for rash, breaks in skin, bruises, etc., and report to charge nurse.

4-5. If the resident has a bowel movement in the tub, take resident out of the tub. Put the resident in a wheelchair or commode chair for cleaning; and cover the resident to keep warm.
   a. Remove feces and deposit in the toilet if possible.
   b. Disinfect the tub with facility approved cleaning agent. Follow directions.
   c. Refill the tub with water and check the temperature.
   d. Return the resident to the tub and continue with the bath.

5. Shampoo bonnets may be ordered from CSR for those who need them.

6. No rinse shampoo is available to the resident who prefers not to water rinse hair.

7. Removing resident from tub:
   a. Refer to NPP D 6.1.0 EZ-Lift Transfer when resident requires a lift transfer.

D. Bathing Resident using the Shower

1. Shower can be provided to a resident using an appropriate shower chair based on function and resident preference. Gather towels, wash cloth, soap, shampoo, robe, shower shoes, if resident has them, and other needed items. Do not take electrical appliances into the shower room.
Tub Baths and Showers and Nail Care

Assist resident to the shower room. Provide privacy. For guidelines using these shower chairs, please refer to:

a. Attachment 3: Operating and Cleaning of Shower Chair Commode, or
b. Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair

2. Use appropriate transfer technique per resident Front Card RCP. Independent resident:
   a. Inform about safety precautions, encourage use of call bell for assistance if needed.
   b. Instruct resident how to apply the chair brakes if shower chair is used.
   c. Instruct him/her to turn on the cold water first, and then slowly open the hot water faucet to add hot water.
   d. Place dry towel within easy reach.
   e. Check the resident frequently.

3. Resident who is independent in showering For resident needing assistance:
   a. Teach resident about safety precautions such as having all necessary materials within reach, applying brakes to shower chair if used, and to test water temperature prior to showering. Turn on the water before the resident gets into the shower. Adjust water flow and temperature, then have resident test it for the desired temperature.
   a.
   b. Instruct resident to call for assistance using nurse call system when needed. A shower chair may be used if resident needs to sit during the shower.
   b.
   c. Periodically check resident for any assistance needed. Privacy may be provided by placing a towel across the lap to avoid completely exposing resident.
   d. Assist resident out of the shower, to dry and to dress.
   d.

E. Grooming

1. Gently apply lotion on resident’s back, legs, and feet.
2. Dress resident or assist with dressing as needed.
3. Clip toenails straight across and shape fingernails. Refer to NPP D5 1.0 Foot Care.
4. Comb hair. Handle hair gently when combing, brushing, or styling to avoid damage.
5. Assist the resident to shave facial hair.
6. Apply makeup with resident’s consent according to her preference.

F. Reporting / Documentation After Bathing

1. Report any abnormal skin changes or any discomfort shall be reported to the Licensed Nurses and documented in the medical record. Make sure the person is comfortable and safe.
2. Bathing preferences and needs are indicated in the Front Card of the Resident Care Plan (RCP) and are included as a care plan problem as needed. Report and/or record your observations to the licensed nurse.
G. Environmental Infection Control

1. Refer to Infection Control Manual

2. The nursing staff are responsible for cleaning and disinfecting the shower chair and tub.

3. Wash nail clippers and soak in approved germicide before using for another resident.

ATTACHMENTS:

Attachment 1: Operating and Cleaning of Tub (Arjo Portable Tub)
Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)
Attachment 3: Operating and Cleaning of Shower Chair Commode
Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair

Routine cleaning of bathroom:

a. Clean tub and shower with the facility-approved cleaning agents. Follow directions.
b. Place soiled linen in hamper.
c. Wash nail clippers and soak in approved germicide before using for another resident.

2. When the resident has an infected wound, including MRSA, wear gloves to clean all surfaces of tub with recommended germicide. Follow manufacturer's instructions for proper use. Rinse well.

REFERENCE:


CROSS REFERENCE:

NPP D2 2.0 Bathing Alternative and Bed Baths
NPP D2 4.0 Operating and Cleaning Jacuzzi Tub
NPP D5 1.0 Foot Care
NPP D6 1.1 Batter-Operated Lift Transfer
LHHP File #24-19 The C-625 Battery Operated Ceiling Lift
NPP D6 1.0 EZ Lift Transfer

Revised: 8/2002, 2/2010; 02/2015
Reviewed: __________
Approved: __________ 12/2009
Operating and Cleaning of the Tub

Operating and Cleaning of the Tub (Arjo Parker Tub) – Attachment 1
LHH Nursing Policies and Procedures

ATTACHMENT 1 - OPERATING AND CLEANING OF THE TUB (Arjo Parker Tub) – change as appendix to bathing

A. POLICY General Guidelines

PROTOCOL:

1. As part of orientation, the competency of all bedside nursing staff to use tub (Arjo Parker Tub) is validated; and annually thereafter as part of their performance appraisal. Licensed Nurses, Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs) will receive training and demonstrate competency on how to operate the tub safely at a minimum during new employee orientation and annually thereafter.

2. Licensed Nurse in collaboration with the Resident Care Team (RCT) is responsible for assessing and planning for the bathing needs and preferences of residents. Resident’s bathing preference should be documented on the Front Card of Resident Care Plan.

3. All other bathing policies apply with the use of Arjo Parker Tub.

2.3 Bath or shower hose water should be no more than 104 degrees.

4.3 Nursing staff should always check the water temperature using the thermostatic panel in the tub at all times when giving a resident a bath.

4. The tub is accessible for residents who are ambulatory; for non-ambulatory resident, a battery-operated lift (i.e. ceiling or EZ-Lift) may be used to transfer resident.

a. For ambulatory resident: Resident can be assisted to the tub seat through the side opening door. The full-length side door must be fully raised for access. Instruct resident to use the internal grab rails to provide support when entering or leaving the tub.

b. For non-ambulatory resident: Resident can access tub using battery-operated lifts (such as ceiling or EZ-Lift). The side door must be fully raised even though resident is being transferred via lift. Instruct resident to use the internal grab rails to provide support when entering tub.

5. Tub must be disinfected and cleaned every after use using the Multi-clean Cleaner/Disinfection System mounted on the wall of the spa/tub room.

B. Operating of the Tub:

1. Prior to giving resident a tub bath, explain the procedure and what the resident would expect when using the tub.

2. Ensure that all tub accessories to be used in bathing (or as resident’s preference) be available within reach or placed in the tub such as suction-cup head rest, buttocks cushion, and leg rest. Leg rest offers leg support and/or may use for podiatry care or treatment during bathing.

3. Resident may use his/her own preferred for shampoo or body wash; or may use the prescribed shampoo or soap if ordered. A liquid-soap dispenser is mounted on the side of the tub which can be also used in dispensing facility-approved shampoo, body wash, or bath oil.

4. Set the desired water temperature of no more than 104 degrees, close the drain, and press the fill button on the control panel to pre-fill the foot well of the tub. Standard preset water level of the tub foot well can hold approximately 23 gallons / 90 liters. Water will automatically shut once it reaches the maximum capacity of the foot well.
5. Once the resident is seated safely inside the tub bath, the door must be closed and ensure that side door lock is fully engaged.

6. Using the hand control, tub can be adjusted to a higher or lower position, or reclined setting.

7. To promote comfort during bathing, gently press the hand control to adjust tub in reclined position. By doing this, water from the pre-filled foot well will glide smoothly to the tub. Always explain to the resident whenever you change the tub setting to avoid startling the resident.

8. Once the tub is in reclining position, if resident prefers, you can activate the air jets to create a “spa-like feel” for promote relaxation and enhance bathing experience.

   The Arjo Parker Tub is equipped with nine air jets with 2 variable speeds. To activate press spa button:
   a. Press once: for light intensity
   b. Press twice: for strong intensity
   c. Press 3rd time: turns the spa jets off

9. A shower hose with three settings is available for shower and rinsing. Always check the water temperature of the shower prior to shower or rinsing the resident.

10. After bathing, using the hand control to return the tub to upright position. This will allow the water flow back to the foot well for draining the tub when the drain is open.

11. Staff can begin to dry the resident’s skin. Once resident is dry, cover resident’s body with a towel. Ensure that the tub is at the lowest, most upright position ensuring resident can transfer safely out from the tub.

12. Once the resident is out of the tub and has safely transferred to chair or wheelchair, you may begin the process of disinfecting and cleaning the tub.

C. Disinfecting and Cleaning of the Tub:

   The Multi-clean Cleaner/Disinfectant System is mounted on the wall above the foot of the tub. This allows cleaning and disinfecting the whole bathtub including the internal panel of the tub, tub surface, handles, control panel, and other tub accessories.

   1. Follow color-coded guide function settings: Yellow for dispensing cleaning agent and Blue for rinsing with water.
   2. Once the disinfecting/cleaning system is turned on, it automatically mixes the cleaning agents and delivers the cleanser to bath surfaces via triggered-action cleaning shower head and through air-spa system for internal hygiene control.
   3. Allow disinfectant to stand for 10 minutes to give disinfectant time to work. Aside from the tub, all tub accessories used must be cleaned and disinfected as well.
   4. Disinfectant dispenser is locked at all times and staff to inform housekeeping if container is less than ¼ full.

D. Tub Maintenance:

   1. Visual check all exposed parts that may contact resident's skin (such as tub accessories, handles, shower hose, spa jets) for any cracks or sharp edges that could potentially cause injuries.
   2. To preserve the rubber seal as the safety lock-feature of the tub’s side door, leave the side door ajar when not in use.
   3. Call Plant Services for any repair or trouble shooting with the Parker Arjo Tub.
   4. Call EVS or housekeeping to refill disinfectant solution

E. Emergency First-Aid in Case of Disinfectant Contamination Exposure:
1. Consult MSDS binder which is available in every neighborhood.
2. In case of contamination, follow first-aid treatment for the following:
   a. Eyes: Flush with running water for at least 15 minutes.
   b. Skin: Remove contaminated clothing and wash affected skin area with running water and soap for at least 15 minutes.
   c. Ingestion: Give 4 glasses of milk (water if milk is not available). Do not induce vomiting. If vomiting occurs, give milk or water again.
3. Notify your supervisor immediately to get appropriate medical attention.

**PURPOSE:**
To promote resident’s safety, relaxation and comfort when using a tub.

**PROCEDURE:**

**A. Operating Tub**
1. Prior to giving resident a tub bath, explain the procedure and what the resident would expect when using the tub.
2. Ensure that all tub accessories to be used in bathing (or as resident’s preference) be available within reach or placed in the tub such as: A tub accessory includes suction-cup head rest, buttocks cushion, and leg rest. Leg rest offers leg support and/or may use for pediatrics care or treatment during bathing. Resident may use his/her own preferred for shampoo or body wash; or may use the prescribe shampoo or soap if ordered. A liquid-soap dispenser is mounted on the side of the tub which can be also used in dispensing facility-approved shampoo, body wash, or bath oil.
3. After setting the desired water temperature of no more than 104 degrees, close the drain, and press the fill button on the control panel to pre-fill the foot well of the tub. Standard preset water level of the tub foot well can hold approximately 23 gallons / 90 liters. Water will automatically shut once it reaches the maximum capacity of the foot well.
4. Transferring resident in/out of the tub using the handset control, place the tub in the most upright position:
   a. For ambulatory resident: Resident can be assisted to the tub seat through the side opening door. The full-length side door must be fully raised for access. Instruct resident to use the internal grab rails to provide support when entering or leaving the tub.
   b. For non-ambulatory resident: Resident can access tub using battery-operated lifts (such as ceiling or EZ-Lift). The side door must be fully raised even though resident is being transferred via lift. Instruct resident to use the internal grab rails to provide support when entering tub.
5. Once the resident is seated safely inside the tub bath, the door must be closed and ensure that side door lock is fully engaged.
Operating and Cleaning of the Tub

Using the hand control, tub can be adjusted to a higher or lower position, or reclined setting.

To promote comfort during bathing, gently press the hand control to adjust the tub in a reclined position. By doing this, water from the pre-filled foot well will glide smoothly to the tub. Always explain to the resident whenever you change the tub setting to avoid startling the resident.

Once the tub is in the reclining position, if the resident prefers, you can activate the air jets to create a "spa-like feel" for promote relaxation and enhance the bathing experience.

The Arjo Parker Tub is equipped with nine air jets with 2 variable speeds. To activate, press the spa button:
- Press once: for light intensity
- Press twice: for strong intensity
- Press 3rd time: turns the spa jets off

A shower hose with three settings is available for showering and rinsing. Always check the water temperature of the shower prior to showering or rinsing the resident.

After bathing, using the hand control to return the tub to an upright position. This will allow the water flow back to the foot well for draining the tub when the drain is open.

Staff can begin to dry the resident's skin. Once the resident is dry, cover the resident's body with a towel. Ensure that the tub is at the lowest, most upright position ensuring the resident can transfer safely out from the tub. (Refer to Procedure #4 regarding transferring the resident).

Once the resident is out of the tub and has safely transferred to a chair or wheelchair, you may begin the process of disinfecting and cleaning the tub.

Disinfecting or Cleaning Tub

The Multi-clean Cleaner/Disinfectant System is mounted on the wall above the foot of the tub. This allows cleaning and disinfecting the whole bathtub including the internal panel of the tub, tub surface, handles, control panel, and other tub accessories.

Follow color-coded guide function settings: Yellow for dispensing cleaning agent and Blue for rinsing with water.

Once the disinfecting/cleaning system is turned on, it automatically mixes the cleaning agents and delivers the cleanser to bath surfaces via triggered-action cleaning shower head and through the air-spa system for internal hygiene control.

Allow disinfectant to stand for 10 minutes to give the disinfectant time to work. Aside from the tub, all tub accessories used must be cleaned and disinfected as well.

Disinfectant dispenser is locked at all times, and staff to inform housekeeping if container is less than ¼ full.

Tub Maintenance

Visual check all exposed parts that may contact the resident's skin (such as tub accessories, handles, shower hose, spa jets) for any cracks or sharp edges that could potentially cause injuries.
2. To preserve the rubber seal as the safety lock feature of the tub’s side door, leave the side door ajar when not in use.

3. Call Plant Services for any repair or trouble shooting with the Parker Arjo Tub.

4. Call EVS or housekeeping to refill disinfectant solution.

D. Emergency First-Aid in Case of Disinfectant Contamination or Exposure

1. Consult MSDS binder which is available in every neighborhood.

2. In case of contamination, follow first-aid treatment for the following:
   - a. Eyes: Flush with running water for at least 15 minutes.
   - b. Skin: Remove contaminated clothing and wash affected skin area with running water and soap for at least 15 minutes.
   - c. Ingestion: Give 4 glasses of milk (water if milk is not available). Do not induce vomiting. If vomiting occurs, give milk or water again.

3. Notify your supervisor immediately to get appropriate medical attention.

ATTACHMENT 1 — Operating the Bath/Tub (Arjo Parker Tub) Competency

REFERENCES:

Arjo Parker Bath/Tub Manual

CROSS REFERENCES:

NPP D2 3.0 Tub Baths and Showers
NPP D6 1.0 Battery-Operated Lift Transfer
HWPP Battery-Operated Ceiling Lift

Adopted from D2 4.5 created on New: 10/2010

Revised: __________ 02/10/2015

Reviewed: __________

Reviewed by _________ and no revision recommended at this time.

Approved: __________
Operating and Cleaning of the Tub – Attachment 1

LHH Nursing Policies and Procedures

Date approved by NEC ________
Date routed to MEC ________
Date emailed to Karina ________
ATTACHMENT 2 - OPERATING THE PORTABLE TUB (Shower Trolley) — change as appendix to bathing

A. POLICY/PROTOCOL: General Guidelines

1. As part of orientation, the competency of all bedside nursing staff to use portable tub (Shower Trolley) is validated; and annually thereafter as part of their performance appraisal. Licensed Nurses, Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs) will be trained how to operate and clean the portable tub.

2. Residents' bathing preferences are assessed and are care planned.

3. Requires 2 caregivers to operate the equipment for safety.

3. Lifting capacity of the equipment is 330 lbs.

4. The portable tub has leveling stretcher platform that allows overlapping on the bed to allow safe, ergonomic lateral transfer which can be used as transport from room to the shower and vice versa.

4. The portable tub has a steering device for smooth transport. Resident must be placed in the middle of the portable tub prior to transport to prevent the tub from tipping over. Check the portable tub is locked in the horizontal position prior transport using the horizontal adjustment lever. Shower or bath is given in the resident's bathroom unless a resident requests Jacuzzi bath in Spa room.

B. Operating Portable Shower Trolley During Shower

1. Activate the portable tub brakes (all 4 wheels) and adjust it to a convenient working height.

2. Adjust the water temperature from the shower control panel.

3. The portable tub provides room to turn the resident for better access during the showering process.

4. The head pillow is helpful when washing the hair.

C. Draining Water from the Shower Trolley

1. Use the horizontal adjustment lever to slope the portable tub gently to allow the water to drain during the shower.

2. The mattress has drain and run-off channels that also speed water drainage.

3. The portable tub has a flexible drain hose which can be placed next to a floor drain or toilet.

D. Cleaning and Disinfecting:

1. Use protective gloves and protective eyewear when using a concentrated disinfectant.

2. Rinse, clean and disinfect the portable tub with facility-approved disinfectant before and after use.

3. Tilt the stretcher facilitate cleaning of its underside.

4. Hang the mattress over the stretcher to dry.

E. Storing Portable Shower Trolley

1. The portable tub stretcher tilts to the side for easy storage in the unit's tub room or storage room.
3.

3.3 F. Emergency First-Aid in Case of Disinfectant Contamination Exposure:

1. Consult MSDS binder which is available in every neighborhood.
2. In case of contamination, follow first-aid treatment for the following:
   a. Eyes: Flush with running water for at least 15 minutes.
   b. Skin: Remove contaminated clothing and wash affected skin area with running water and soap for at least 15 minutes.
   c. Ingestion: Give 4 glasses of milk (water if milk is not available). Do not induce vomiting. If vomiting occurs, give milk or water again.

29.3 Notify your supervisor immediately to get appropriate medical attention.

PURPOSE:

To promote safe assisted showering and comfort for residents on a recumbent position.

PROCEDURE:

A. How to use the Portable Tub

1. Transport
   a. Resident can be transferred to the portable tub with an electric lift, the ceiling lift, sliding board or transfer from wheelchair to the portable tub.
   b. The portable tub has leveling stretcher platform that allows overlapping on the bed to allow safe, ergonomic lateral transfer which can be use as transport from room to the shower and vice versa. Raise the 2 handed grip side supports and snap into a secured position.
   c. The portable tub has a steering device for smooth transport.
   d. Raise the portable tub to a comfortable height for transport.
   e. Check that the portable tub is locked in the horizontal position prior transport using the horizontal adjustment lever.
   f. Check that the resident is in the middle of the portable tub prior to transport to prevent the tub from tipping over.
   g. Requires 2 care givers to operate the equipment for safety.
   h. Lifting capacity of the equipment is 330lbs.

2. Shower
   a. Activate the portable tub brakes (all 4 wheels) and adjust it to a convenient working height.
   b. Adjust the water temperature from the shower control panel.
   c. The portable tub provides room to turn the resident for better access during the showering process.
   d. The head pillow is helpful when washing the hair.

3. Draining of Water
Operating the Portable Tub

a. Use the horizontal adjustment lever to slope the portable tub gently to allow the water to drain during the shower. The mattress has drain and run-off channels that also speed water drainage. The portable tub has a flexible drain hose which can be placed next to a floor drain or toilet.

b. Towel dry the resident and assist resident to put on clothes.

B. Cleaning/disinfection and Storing the Portable Tub

B.1. Use protective gloves and protective eyewear when using a concentrated disinfectant. If contact of disinfectant occurs, please refer to the emergency first aid on procedure C.

1. The portable tub is rinsed, cleaned and disinfected the portable tub with facility approved disinfectant before and after use.

2. Tilt the stretcher. The mattress is easily removed to facilitate cleaning of its underside, and the stretcher.

3. The portable tub stretcher tilts to the side for easy cleaning and storage.

4. Hang the mattress over the stretcher to dry.

C. EMERGENCY FIRST-AID

1. Consult MSDS binder which is available in every neighborhood.

2. Eyes: Flush with running water at least 15 minutes.

3. Skin: Remove contaminated clothing and wash the area with running water and soap for at least 15 minutes.

4. Ingestion: Give 4 glasses of milk (water if milk is not available). Do not induce vomiting. If vomiting occurs give milk or water again.

5. Notify the charge nurse or nurse manager for area supervision STAT immediately and get immediate medical attention.

REFERENCES:


Arjo Concerto Manual
ATTACHMENT 3 - MULTIPURPOSE HYGIENE (SHOWER) CHAIR COMMODE

A. Operating Guidelines

POLICY:

1. As part of orientation, the competency of all bedside nursing staff to use shower chair commode is validated; and annually thereafter as part of their performance appraisal, Licensed Nurses, Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs) will be trained on how to operate and clean the hygiene chair.

2. The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility. All bathing, toileting, and incontinent care policies apply.

3. Prior to a resident's use of the shower chair commode, nursing staff must assess and ensure that the resident fits the following criteria in order to provide resident safety. Resident must be assessed prior to using the hygiene chair according to the following criteria:
   a. Weight does not exceed 250 lbs. (113 kg).
   b. Has good trunk control and does not lean sideways or forward. Resident should be able to sit upright, self-supported on the side of a bed or a toilet.
   c. Does not exhibit involuntary movements.
   d. Is not restless and is able to follow directions.
   e. Resident care plan states that the resident prefers and may use the shower chair commode for bathing. The resident should understand and be able to follow instructions to stay seated in an upright position.

4. Hygiene chair can be used for toileting residents.

PURPOSE:

To provide a range of hygiene routines such as showering, washing hair, foot care, toileting, changing clothes, and incontinent briefs.

BACKGROUND:

Multipurpose hygiene chair is a multifunction chair incorporating reclining features and a handset control for adjusting the height of the chair so caregivers may provide care ergonomically.

PROCEDURE:

A. Operating Shower Chair Commode

A. Before each use of the shower chair commode, nursing staff must:
   A.
   A. Check the seat cushion to ensure that it is properly installed and firmly clipped to the back of the seat frame to prevent the seat from slipping forward.
   A. Check the side knobs to ensure that they are tightly screwed to the seat frame to prevent the seat belt from disengaging.

A.2 Transfer and transport of resident:
   A.a. When transferring a resident in and out of the shower chair commode, lock all four wheels on shower chair by depressing each of the red foot pedals located on all four wheels.
   A.b. Resident may transfer in and out of the shower chair via E-Z lift, ceiling lift, or transfer from chair to shower chair.
   A.c. Apply and adjust the seat belt according to resident size and comfort, ensure that the belt snaps on and the resident is not leaning forward.
   A.d. For resident privacy and dignity, ensure the resident is properly clothed / covered during transport.

A.3 Shower
   A.a. Park the shower chair commode by locking its wheels to prevent shower chair from rolling away.
   A.b. Do not leave resident unattended while in the shower chair.
   A.c. Continually monitor resident to ensure safety.

A.C. Cleaning and Disinfecting of Shower Chair Commode
   A.1. The shower chair commode must be cleaned after each use with the facility approved disinfectant.

A.D. Maintenance

How to use the Multipurpose Chair

Refer to the operating care instructions on the Multipurpose Hygiene chair (Care raiser-Carendo by Arjo) available in your household.

Alert Information:

1. Ensure that the genitalia of male residents do not slide into the aperture during the lowering movement of the seat. CNA/PCA/HHA to inform licensed nurse if the shower chair commode is broken.

2. Licensed Nurse will call Plant Services for any repair or services as needed.

3. The Licensed Nurse may also submit a “work order web request” by clicking “Plant Services Work Request” on the Laguna Honda Intranet. An email alert will be sent on change of status.

REFERENCES:

Aquatec Manual
Care Raiser-Carendo by Arjo Manual Instructions

CROSS REFERENCES:

NPP D2 3.0 Tub Baths and Showers
NPP D6 1.0 Battery Operated Lift Transfer
HWPP Battery Operated Ceiling Lift

2
Adopted from D2 4.7 created on 10/2010
New: 10/2010
Reviewed: 11/16/10; 01/31/2011
Revised: __________02/2015
Reviewed: __________
Reviewed by ________ and no revision recommended at this time.
Approved: __________

For Ghe use only:
Date sent to Policy Reviewer __________
Date received from Policy Reviewer __________
Date reviewed by NEC __________
Date approved by NEC __________
Date routed to MEC __________
Date emailed to Karina __________
ATTACHMENT 4 – MULTIPURPOSE HYGIENE SHOWER CHAIR COMMODE OPERATING GUIDELINES

A. General Guidelines

1. Definition: As part of orientation, the competency of all bedside nursing staff to use multipurpose hygiene shower chair is validated; and annually thereafter as part of their performance appraisal.

A.2. Multipurpose hygiene chair is a multifunction chair incorporating reclining features and a handset control for adjusting the height of the chair so caregivers may provide care ergonomically.

A.3. Hygiene chair can be used for toileting residents.

A.4. Resident must be assessed prior to using the hygiene chair according to the following criteria:

   A.a. weight should not exceed 136 kg (300 lbs).
   A.b. resident should able to sit upright, self-supported on the side of a bed or a toilet, and the resident should understand and able to follow instructions to stay seated in an upright position.

The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility.

B. Resident Assessment Prior to Use of the Shower Chair Commode

B.1. Refer to the operating care instructions on the Multipurpose Hygiene chair (Care Raiser-Carendo by Arjo) available in your household.

B.2. Alert Information: Ensure that the genitalia of male residents do not slide into the aperture during the lowering movement of the seat.

B.C. Cleaning and Disinfecting Hygiene Shower Chair

B.1. The shower chair commode must be cleaned after each use with the facility approved disinfectant.

D. Maintenance of Hygiene Shower Chair

B.1. CNA/PCA/HHA to inform licensed nurse if the multipurpose hygiene chair commode is broken.

B.2. Licensed Nurse will call Plant Services for any repair or services as needed. The Licensed Nurse may also submit a “work order web request” by clicking “Plant Services Work Request” on the Laguna Honda Intranet. An email alert will be sent on change of status.
Prior to a resident’s use of the shower chair commode, nursing staff must assess and ensure that the resident fits the following criteria in order to provide resident safety:

a. Weight does not exceed 250 lbs.

b. Has good trunk control and does not lean sideways or forward.

c. Does not exhibit involuntary movements.

d. Is not restless and is able to follow directions.

e. Resident care plan states that the resident prefers and may use the shower chair commode for bathing.

C. Operating the Shower Chair Commode:

1. Before each use of the shower chair commode, nursing staff must:
   a. Check the seat cushion to ensure that it is properly installed and firmly clipped to the back of the seat frame to prevent the seat from slipping forward.
   b. Check the side knobs to ensure that they are tightly screwed to the seat frame to prevent the seat belt from disengaging.

2. Transfer and transport of resident:
   a. When transferring a resident in and out of the shower chair commode, lock all four wheels on shower chair’s by depressing each of the red foot pedals located on all four wheels.
   b. Resident may transfer in and out of the shower chair via E-Z lift, ceiling lift, or transfer from chair to shower chair.
   c. Apply and adjust the seat belt according to resident size and comfort, ensure that the belt snaps on and the resident is not leaning forward.
   d. For resident privacy and dignity, ensure the resident is properly clothed / covered during transport.

3. Shower:
   a. Park the shower chair commode by locking its wheels to prevent shower chair from rolling away.
   b. Do not leave resident unattended while in the shower chair.
   c. Continually monitor resident to ensure safety.

D. Care and Maintenance of the Shower Chair Commode:

1. The shower chair commode must be cleaned after each use with the facility approved disinfectant.

2. CNA/PCA/HHA to inform licensed nurse if the shower chair commode is broken. Licensed Nurse will call Plant Services for any repair or services as needed. The Licensed Nurse may also submit a “work order web request” by clicking “Plant Services Work Request” on the Laguna Honda Intranet. An email alert will be sent on change of status.

REFERENCE:

Care Raiser-Carendo by Arjo Manual Instructions Aquatec Manual

Adopted from M 14.0 created in New Document – 03/27/2012
INTRAVENOUS (I.V.) THERAPY MAINTENANCE

POLICY:

1. The competent Registered Nurse (RN) is responsible for the administration, monitoring, and maintenance of intravenous (I.V.) therapy and subcutaneous (S.C.) therapy including monitoring complications.

2. The administration of I.V fluids requires a physician’s order. The physician’s order must include the type of IV solution, rate of administration and/or duration of administration and also must specify medication additives (i.e. name of drug, dosage and specific fluid amount).[w1]

3. An RN may administer I.V. push medications only in emergency situations under direct physician’s supervision.

4. If the I.V. is designated as to maintain patency of an I.V. line, the order must specify the desired infusion rate. An I.V. designated only as “to keep vein open (TKO)” or “keep vein open (KVO)” should be infused at 30cc per hour not unless otherwise ordered. Use an I.V. pump for all I.V. infusions.

5. Peripheral I.V. site is to be changed or rotated every seventy-two ninety-six (7296) hours or earlier if necessary.[w2] An RN may restart peripheral I.V. site without a physician’s order if the I.V. site is infiltrated, inflamed or has dislodged as needed. All I.V. containers are changed every 24 hours and PRN according to physician’s orders.[w3]

6. Aseptic technique is used throughout the procedure. Body substance precautions must be observed. Gloves are worn to perform venipuncture and other vascular access procedures. Used I.V. equipment will be disposed of accordingly.[w4]

7. An I.V. certified by State of California Licensed Vocational Nurse (LVN) who demonstrated competency with I.V. therapy may perform these following procedures under the supervision of an RN:
   a. Perform venipuncture; may start, monitor, and discontinue I.V.
   b. Superimpose peripheral I.V. containers
   c. Change I.V. tubing of intravenous peripheral intravenous lines

   * LVN cannot perform the following procedures:
   a. Administer I.V. medications
   b. Superimpose central line I.V. fluid containers
   c. Change central line I.V. tubing
   d. Discontinue central line or sutured I.V. lines
   e. Change central line I.V. dressings
   f. Administer fluids at an unspecified rate (i.e. “bolus wide open”)

8. Peripheral I.V. needles/catheters will be connected to needleless I.V. administration system and capped lines.

9. Intake and output is monitored and documented every shift for a resident who is on continuous I.V. therapy.

PURPOSE:
Intravenous (I.V.) Therapy Maintenance

To provide guidelines for licensed nurses RN with management of I.V. therapy, fluid hydration, maintain or correct fluid and electrolyte balance, and to administer medications through a variety of methods using continuous and/or variety intermittent infusion.

RELEVANT DATA:

1. Peripheral venous catheter is usually inserted in veins of forearm or hand using a I.V. cannula defined as insertion of a small flexible cannula through the patient’s skin and into the vein. The end catheter of a peripheral I.V. line does not end in a great vessel.

2. Internal Jugular (I.J), External Jugular (E.J.), Peripherally Inserted Central Catheter (PICC) lines are to be managed as central lines; aseptic technique dressing changes are only done by RNs.

PROCEDURE:

A. Equipment:

<table>
<thead>
<tr>
<th>Item</th>
<th>Obtained from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.V. administration set -(60gtt/ml)</td>
<td>Omni cell</td>
</tr>
<tr>
<td>I.V. secondary set -(piggy back)</td>
<td>Omni cell</td>
</tr>
<tr>
<td>Venipuncture catheter, appropriate sizes (22g, 20g, 18g)</td>
<td>Neighborhood/CSR</td>
</tr>
<tr>
<td>Clear link luer lock intermittent injection site tubing</td>
<td>Omni cell/CSR</td>
</tr>
<tr>
<td>I.V. pressure hub</td>
<td>Omni cell/CSR</td>
</tr>
<tr>
<td>I.V. starter kit (should have chloraprep in pkg)</td>
<td>Omni cell/CSR</td>
</tr>
<tr>
<td>I.V. solutions</td>
<td>Pharmacy/Omni cell</td>
</tr>
<tr>
<td>I.V. minibag bag (NS or D5W) in 25, 50 or 100ml</td>
<td>Pharmacy/Omni cell</td>
</tr>
<tr>
<td>Chloraprep Antiseptic pads</td>
<td>CSR/Omni cell</td>
</tr>
<tr>
<td>Gloves, Sterile and Non-sterile gloves</td>
<td>Pharmacy/Omni cell</td>
</tr>
<tr>
<td>Prescribed I.V. medications</td>
<td>Pharmacy/Omni cell</td>
</tr>
<tr>
<td>I.V. and medication labels</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>I.V. Flow sheet</td>
<td>Neighborhood</td>
</tr>
</tbody>
</table>

B. Preparation for peripheral I.V. insertion

1. Check physician’s orders prior to initiation of I.V. therapy. The physician’s order must include the type of I.V. solution, rate of administration and/or duration of administration and also must specify medication additives (i.e. name of drug, dosage and specific fluid amount). [wu7]

2. Ensure that I.V. fluids and additives are compatible by referring to compatibility chart, I.V. Administration Guideline, Lexicomp (online formulary) or verifying with the Pharmacy.

3. Wash hands prior to palpation, inserting, replacing, or dressing any I.V. Wear clean gloves.

4. Prepare I.V. fluids and medications in designated medication room; cleanse preparation site with antiseptic pads 70% alcohol prior to each preparation.

5. Label I.V. tubings and fluid bag container with the date time, type of fluid and type of additives, and the name, initial of the RN person preparing the I.V. ad mixture.
Intravenous (I.V.) Therapy Maintenance

6. Select an appropriate site for insertion.

6. Evaluation of Peripheral I.V. Site
   a. Inspect and gently palpate the area around the infusion site each shift and as needed.
   b. Assess for inflammation, blanching, discharge, hardness, swelling, pain, or temperature change (warmer or cooler). If complications are evident, change the infusion site.

7. Peripheral I.V. insertion (Saline-lock without extension tubing)
   a. Fill one syringe with 1-2 ml of normal saline solution or the solution ordered by the physician.
   b. Wash hands. Put on sterile gloves and perform venipuncture.
   c. Quickly connect the intermittent infusion site into the safety I.V. catheter port and release tourniquet.
   d. Secure I.V. needle in place with transparent dressing or tape.
   e. Clean injection port with antiseptic pads and instill pre-filled 3 ml of normal saline solution or prescribed solution. Remove gloves. Wash hands.

8. Set and monitor the I.V. flow rate on the infusion pump. Monitor flow, the appearance of the infusion site and the response of the resident to the treatment periodically.

9. If peripheral I.V. is an intermittent lock, flush with pre-filled normal saline every 8 hours, and before and after each administration of medication; unless otherwise indicated. Adjust I.V. flow rate on the I.V. pump as prescribed. The RN/LVN may not increase the rate to provide a fluid bolus without a physician’s order. Fluids infused too rapidly may result in untoward clinical effects.

   If peripheral I.V. is an intermittent lock, flush with 5 ml pre-filled normal saline every 8 hours, and before and after each administration of medication; unless otherwise indicated. Using positive pressure valve, sterile normal saline is used to flush the tube after each medication, intravenous infusion or blood sampling. (Sterile water is used to flush when administering drugs which are incompatible with normal saline).

10. Administering Medications (Refer to NPP J 1.0 Medication Administration)

   1. Refer to NPP J 1.0 Medication Administration. For Intravenous Push (IVP) Medication refer to NPP J 4.0.

   2. For I.V. fluids and additives are compatible by referring to compatibility chart, I.V. Administration Guideline, Lexicomp (online formulary) or verifying with the Pharmacy.

   2. When administering chemotherapy I.V. medication refer to LHPP 70-02. I.V. piggy back medication is given using the I.V. secondary set.

   3. Check for physician’s order. Ensure that I.V. fluids and additives are compatible by referring to compatibility chart, I.V. Administration Guideline, Lexicomp (online formulary) or verifying with the Pharmacy.

   3. When administering chemotherapy I.V. medication refer to LHPP 70-02.
D. Maintenance of I.V. Site

1. **PRotate peripheral I.V. site may be in place up to every 72-96 hours.** If the I.V. line is not changed in 72-96 hours, notify MD and document reason (i.e. poor vein access, resident refused I.V. site change), in the Interdisciplinary Progress Notes and notify the physician. If venous access is limited, request physician order to extend use of the current site.

2. If the peripheral I.V. infusion site indicates infiltration, inflammation, discontinue I.V. needle or catheter and start a new I.V. line.

3. If peripheral I.V. is an intermittent lock, flush with 5 cc normal saline every 8 hours, before and after each administration of medication. Sterile normal saline is used to flush the unit after each medication, intravenous infusion or blood sampling. (Sterile water is used to flush when administering drugs which are incompatible with normal saline).

4. I.V. primary and secondary tubing is changed every 72-96 hours (unless there is contamination or drug incompatibility, may change as needed).

5. I.V. solution is changed every 24 hours.

6. I.V. transparent dressing is changed with each site change and as needed every 72 hours unless soiled, may change as needed. Transparent dressing is used to be able to evaluate I.V. site without removing the dressing.

5. For resident with fragile skin, consider use of the skin barrier prep prior to applying tape around the periphery of transparent dressing. May apply: Fishnet Elastic net dressing to secure I.V. site when needed to keep resident’s hand from pulling at I.V. tubing or removing I.V. catheter.

6. **Evaluation of Peripheral I.V. Site**
   
a. Inspect and gently palpate the area around the infusion site each shift and as needed.
   b. Assess for inflammation, blanching, discharge, hardness, swelling, pain, or temperature change (warmer or cooler). If complications are evident, change the infusion site.

7. **Discontinuing Peripheral I.V. site:**

1. After hand washing and applying clean gloves, gently remove any tape or dressing after pressure with a 2 x 2 sterile dressing for 1-2 minutes or longer to prevent hematoma formation at the I.V. site.

2. Place dry dressing or Band-aid over the insertion site.

3. Any I.V. related products with visible blood are dispose in the sharps container. Dispose of used equipments observing Universal Precautions.

F. Reporting and/or Documentation

1. I.V. Flow Sheet
Intravenous (I.V.) Therapy Maintenance

- Document procedure, date, time, bag number for continuous I.V. fluids; volume hung, type of solution, flow rate, type of line, site location and needle gauge and signature.
- Each shift, document I.V. site assessments, dressing or tubing changes, amount infused, amount left in bottle and signature.
- Document on the back of PRN form:
  - Unusual findings on I.V. site
  - Difficulties encountered and how the resident tolerated the treatment

2. Treatment Administration Record Graphic Sheet

 Record intake and output every shift. The 24-hour total is done on PM Shift.

4. Medication Administration Record Sheet

- Document dosage and time of I.V. piggy back or I.V. Push medications administered.
- Saline flush maintenance instillations must be recorded separately on medication sheet unless the resident receives an intravenous medication at least every eight hours.

5. Interdisciplinary Progress Notes

- Document Report complications immediately to the physician.
- Report type and amount of remaining solution, rate of flow and any special considerations to relief nurse.

REFERENCE:

Nettina, S. The Lippincott Manual of Nursing Practice (9th Ed, 2010)
CDC Guidelines for Prevention of Intravenous Therapy

CROSS REFERENCE:

Nursing P&P J 1.0 Administration of Medications
Nursing P&P J 4.0 IntraVenous Push (IVP) Medication Administration
Nursing P&P J 7.0 Central Venous Access Device Management
LH Infection Control Manual Policy C6 Intravascular Device Guidelines (LHH intranet site)
LHP 70-02 Antineoplastic/Cytotoxic Medications
CDC Guidelines for Prevention of Intravenous Therapy—Related Infections

RDocument revised: 8/2000, 6/2010; 03/10/2015
Reviewed: 03/10/2015
Wound Assessment and Management

**POLICY:**

1. The Registered Nurse (RN) is responsible for performing wound assessment, dressing application, and notifying the physician for presence of wound infection, wound deterioration, and non-healing wound.

1.2. The Licensed Vocational Nurse (LVN) under the supervision of the RN may collect wound assessment data and perform dressing application as ordered by the physician.

**PURPOSE:**

1. To provide a guideline in wound assessment and appropriate wound management to protect the wound from injury, prevent introduction and spread of bacteria, reduce discomfort and promote healing.

**BACKGROUND:**

**A. Definitions:**

1. **Arterial** - wounds caused by ischemia, which is related to the presence of arterial occlusive disease.

2. **Diabetic or Neuropathic** - Neuropathy is often associated with diabetes. Wounds result from damage to the autonomic, sensory, or motor nerves and have an arterial perfusion deficit.

3. **Pressure** – wounds due to the damage to the skin or underlying structures as a result of tissue compression and inadequate perfusion.

4. **Venous** – wounds caused by failure of the venous valve function to return blood from the lower extremities to the heart. This causes venous congestion and leads to venous hypertension.

<table>
<thead>
<tr>
<th>Types of Wound</th>
<th>Arterial</th>
<th>Diabetic/Neuropathic</th>
<th>Pressure</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>The distal aspect of arterial circulation can be anywhere on the leg, including the toes and feet</td>
<td>Can be anywhere on the lower extremity, usually located on the foot</td>
<td>Usually over a bony prominence</td>
<td>Located in the gaiter area (ankle to mid-calf), it is often medial malleolus and maybe circumferential</td>
</tr>
<tr>
<td><strong>Wound Margin</strong></td>
<td>“Punched out,” well-defined borders</td>
<td>“Punched out,” Usually with a calloused edge</td>
<td>Usually circular</td>
<td>Irregular shaped</td>
</tr>
<tr>
<td><strong>Wound Size</strong></td>
<td>Can be small, but often increases due to lack of arterial perfusion</td>
<td>Often small</td>
<td>Can be very large or very small</td>
<td>Usually large</td>
</tr>
<tr>
<td><strong>Wound Bed</strong></td>
<td>Pale wound bed, little or no granulation, necrotic tissue is common</td>
<td>Similar to arterial wounds, usually with a calloused edge</td>
<td>Can have viable or necrotic tissue</td>
<td>Usually shallow, can have viable or necrotic tissue</td>
</tr>
</tbody>
</table>
## Wound Assessment and Management

**LHH Nursing Policies and Procedures**

**Wound Assessment and Management**

### Exudate
- Minimal to no exudate

### Types of Wound
<table>
<thead>
<tr>
<th>Arterial</th>
<th>Diabetic/Neuropathic</th>
<th>Pressure</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate to heavy</td>
<td>Usually seen, absent or severe</td>
<td></td>
<td>Generalized edema to lower extremity</td>
</tr>
<tr>
<td>Often present, but untreated</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Edema
- If present, localized
- If present, localized
- Can be localized, usually not seen
- Generalized edema to lower extremity

### Pain
- Occurs at rest, at night, or when the extremity is elevated
- Due to neuropathy, the pain maybe absent or severe
- Usually present, but undertreated
- Often occurs in a dependent position along with edema

### Best Practice

<table>
<thead>
<tr>
<th>Arterial</th>
<th>Diabetic/Neuropathic</th>
<th>Pressure</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If perfusion is not adequate, consider vascular consult</td>
<td>1. Maintain optimal moisture</td>
<td>1. Remove necrotic tissue</td>
<td>1. Compression</td>
</tr>
<tr>
<td>2. If perfusion is adequate, follow protocol based on wound assessment and characteristics</td>
<td>2. Control diabetes, if appropriate</td>
<td>2. Maintain optimal moisture</td>
<td>2. Remove necrotic tissue</td>
</tr>
<tr>
<td></td>
<td>5. Remove pressure with appropriate off-loading shoe or other appliance</td>
<td>5. Remove pressure</td>
<td>5. Control bioburden</td>
</tr>
</tbody>
</table>

### PROCEDURE:

A. Management of Pressure Ulcer – refer to LHHPP 24-15 Management of Pressure Ulcers.

B. For management of arterial, diabetic/neuropathic, or venous wounds, refer to table under Background section.

Note: For wounds that would require compression dressing, refer to Attachment 1: Two Layer Compression Bandage System

A. Refer to:

- Nursing Interventions & Clinical Skills, 2nd edition, 2000
- Pressure Ulcers and Wound Care Management, Pages 565-584
- Applying Dressings, Pages 585-594
- Applying Binders and Bandages, Pages 594-599

C. Use Care of Advanced Wound Products Specific to Skin Substitutes and Extracellular Matrix (ECM) (skin substitutes and extracellular matrix-ECM)

1. Special dressing specifically the skin substitutes and ECM are only applied in the Outpatient clinic, only. Refer to Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM.

2. To prevent damage of the newly applied product, the primary dressing is left in place up to 7 days. Note will write one separate as attachment.

3. Secondary dressing is changed when soiled or dislodged.
B.D. Documentation and Reporting

1. Treatment Administration Record (TAR)
   1.a. Sheet. Initial documentation of dressing application of treatment ordered.

2. Wound Assessment Record (W.A.R.)
   2.a. Document a complete wound assessment (e.g., location, description of wound, including size, quantity and quality of drainage if present, progress towards healing and when deterioration of the wound is observed or suspected) weekly.

3. Interdisciplinary Progress Notes
   a. Report any undue bleeding, untoward reactions to the physician; and document.
   b. Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.

4. Resident Care Team (RCT)
   a. RCT Report any undue bleeding, untoward reactions to the physician; and document.
      Conduct a meeting for new onset or worsening of wound.
      Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.
      Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.

ATTACHMENTS:

Attachment 1: Two Layer Compression Bandage System
Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM
Attachment 3: Wound Assessment Record (MR #____)

REFERENCES:

The Wound Care Handbook from Medline Industries (2007)
Nursing Interventions and Clinical Skills, 2nd Edition, 2000; Elkin, Perry, Potter

CROSS-REFERENCES:

LHPP 24-15 Management of Pressure Ulcers
NPP K 1.0 Pressure Ulcer Prevention and Treatment
Unit Binder: Solutions: Algorithm for Wound Care[GEM5]
NPP C 4.0 Notification and Documentation for Change in Resident Status
Attachment 1: Two Layer Compression Bandage System

Definition:

Coflex® TLC two layer compression bandage system delivers a light therapeutic compression to manage edema up to 7 days.

Features:

1. Compression bandage system is ideal for venous-type ulcers.
2. Advanced two-layer compression system provides support and compression to feet and legs.
3. Sizes varies from S to XL.
4. Layer 1 is a soft foam with an absorbent coating (blue contact layer) that wicks away moisture and helps control odor.
5. Layer 2 is a soft foam with an absorbent coating (blue contact layer) that wicks away moisture and helps control odor.
6. Both layers are not made with natural rubber latex free and bond together when applied which keeps the system in place.
7. A nylon stocking is included to apply over the completed dressing for patient comfort and ease of movement under clothes and on bed sheets.
8. Comfortable and lightweight for increased patient compliance.

Application of Spiral Wrapping Technique:

Layer 1:

1. Flex the foot to 90 degrees and apply Layer 1 (Blue coating facing the leg) in two turns starting at the base of the toes.
2. Proceed up and around ankle, covering the Achilles tendon.
3. Return over the top of the ankle and down to secure the heel. Cover all exposed skin of the heel.
4. Wrap in a spiral up to the leg. While wrapping, overlap the bandage by half of the width of the bandage.
5. Finish below the heel and discard any unused bandage. Secure layer 1 (padding) with tape.

Layer 2:

1. Follow same the above procedure (from 1 to 5) using Layer 2 (cohesive bandage). Cohesive bandage must be at or near full stretch. The cohesive bandage will adhere itself.
Attachment 2: Skin Substitutes and Extracellular Matrix (ECM) Products

Indication:

Use with chronic wound that has not responded to optimal care (including both systemic and local wound management) and after all necrotic tissue, fibrinous slough, and surrounding callus has been debrided, to promote wound healing. Applied in Laguna Honda Outpatient Clinic only.

Background: Skin substitutes and Extracellular Matrix (ECM) can be classified as cellular (i.e., containing living cells) or acellular.

Cellular products are frequently referred to as skin substitutes and acellular products as extracellular matrix (ECM) scaffolds.

These products may be:

1. autologous (derived from the patient’s body)
2. allogeneic (derived from other humans, also called homografts)
3. xenographic (derived from non-human sources, e.g., porcine, bovine, equine, avian (also called heterografts)
4. biosynthetic (biological and manmade materials)
5. synthetic (man-made materials)

<table>
<thead>
<tr>
<th>Cellular Products</th>
<th>Acellular Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contains living cells consists of autologous or allogeneic keratinocytes and/or fibroblasts and the ECM proteins and growth factors produced by these cells.</td>
<td>Nonliving produced from allogeneic, xenographic, biosynthetic materials.</td>
</tr>
<tr>
<td>Epidermal skin substitute are cultured keratinocytes taken as a biopsy either from the patient (autograft) or from another human (allograft).</td>
<td>Most commonly referred to as ECM scaffolds.</td>
</tr>
<tr>
<td>Dermal skin substitute contain fibroblasts seeded and cultured on a bioabsorbable matrix along with the ECM proteins and growth factors that they produced.</td>
<td>Xenographic porcine (Oasis Wound Matrix)</td>
</tr>
<tr>
<td>Bi-layered skin substitute is a living allogeneic bi-layered skin substitute consisting of keratinocytes and fibroblast.</td>
<td>Apligraf</td>
</tr>
</tbody>
</table>
WARMING CABINET BLANKET WARMER PROTOCOL

1. Blanket warmer (no lower limit 80 – 135 degrees F) normal operating temperature set no higher than 130 degrees F.

1.1 Nursing is responsible for checking blanket warmer temperature. Refer to LHHPP 31-01 Wireless Temperature Monitoring System. As part of orientation, the competency of all bedside nursing staff to use warming cabinet blanket warmer are validated; and annually thereafter as part of their performance appraisal.

Licensed Nurse is to check temperature of the blanket warmer daily by logging on the Temp Track [WU1].

3. When a “blanket warmer out of range” alert is activated, the charge nurse or designee will respond by checking the blanket warmer for possible causes and adjusting the temperature when needed.

4. To eliminate the alarm sounding off from the equipment, open door, turn thermostat dial down to 130 degrees F, wait for thermostat to read 130 degrees F, then close door.

2.5 The warming cabinet blanket warmer acceptable temperature is between 90-160 set no higher than 130 degrees F. Only blankets, muslin or cotton sheets, or wool blankets are kept in the warming cabinet blanket warmer.

3.6 Report any broken or non-functioning blanket warmer by calling or submitting work order to Facility Services for any repair or services as needed. All nursing staff shall inform licensed nurse if the stretcher blanket warmer is broken or not functioning. Licensed Nurse will call or submit work order to Plant Facility Services for any repair or services as needed.

4. Avoid setting the warming cabinet blanket warmer on the over temperature alarm:
   a. Do not set the lower compartment more than 30 degrees F warmer than the temperature setting for the upper compartment.
   b. If “Over Temperature” indicating light and alarm activates under normal operating conditions, call Facility Services [WU2].

5.7 The warming cabinet blanket warmer must be cleaned with facility approved stainless steel cleanser. Use detergent solution to wash all non-stainless surfaces; and rinse with tap water. Using sponge or damp cloth, wipe dry.

APPENDIX:

Appendix 1 – Quick Reference – Operating Warming Cabinet Blanket Warmer

REFERENCE:

Steris® Amsco® Warming Cabinet Operator Manual

CROSS-REFERENCE:

LHHPP File 31-01 Wireless Temperature Monitoring System
APPENDIX 1 – OPERATING BLANKET WARMER QUICK REFERENCE

Operating Warming Cabinet

1. Start
   a. To start the warming cabinet, slide access door to the left to expose controls and then press the power switch on.

2. Load
   a. To load blankets or sheets, open the heating compartment door and place the articles to be heated in the chamber. Close the cabinet door.
   b. Loading techniques
      i. Never overload the cabinet or stack items beyond the recommended limits (no more than 5 blankets).
      ii. All loads should be allowed to stabilize at the set temperature.
      iii. If it is necessary to remove only part of a load from the cabinet, then a FIFO (First In First Out) routine is recommended.
      iv. PCA or CNA may check blanket's temperature by feeling by hand if the blanket is safe enough to be given to the resident.

3. Setting Temperature
   a. Temperature Control Knob
      i. To set temperature, set the temperature control knob(s) for the desired temperature in the 2 compartment model:
         a) The upper knob controls the temperature for the upper chamber
         b) The lower control knob controls the lower compartment
      ii. Slide control door to the right to close the blanket warmer.
      iii. The temperature setting may be changed when desired, however reducing the temperature may activate the over temperature alarm buzzer.
   b. To deactivate "Over Temperature" light and alarm
      i. The "Over Temperature" indicator light and alarm will be activated if the temperature is lowered down from the initial temperature setting.
      ii. To deactivate the light and alarm:
         a) Open the door to release the heated air.
         b) After the temperature is lowered down (will show in the LCD display screen), close the cabinet door.
         c) If the "Over Temperature" indicator light and audible alarm remains on, turn the temperature control knob to "OFF" and allow more cooling time while keeping the door open.
         d) Once the chamber has cooled down, turn the temperature control knob to the appropriate temperature.
         e) Close the compartment door.
         f) Allow adequate time for the materials to reach desired temperature.
HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:
High-level chemical disinfection is performed by trained and qualified Clinic Staff according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

PURPOSE:
High-level chemical disinfection is a process used for the disinfection of semi-critical resident care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores.

PROCEDURE:
1. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments" and to LHH Outpatient Clinic Policy C3 "Cleaning of Medical Instruments Prior to Disinfection and Sterilization".

2. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.

3. Hospital approved high-level disinfectants must be used.
   Chemicals are mixed, stored and used in accordance with manufacturer’s recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

4. Refer to Appendix A for Specific instructions on the use of Cidex plus® OPA Solution (ortho-Phthalaldehyde 0.55%) for high-level disinfection.

5. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and Legionella.

Reference:
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"

Revised:
Appendix A: Use of Cidexplus® OPA Solution (ortho-Phthalaldehyde 0.55%) for High-Level Chemical Disinfection

For Complete information on use refer to Cidexplus® OPA Product information

1. Material Compatibility

For compatibility of device materials with Cidexplus® OPA refer to device manufacturer's recommendations and Cidexplus® OPA Product information.

2. Cleaning Agent Compatibility

Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus® OPA Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus® OPA Solution.

3. Safety

Caution: Contains Ortho-Phthalaldehyde
- Harmful by inhalation and if swallowed
- Irritating to respiratory system and skin
- Risk of serious damage to eyes
- May cause sensitization by inhalation and skin contact

Precautions
- Wear suitable protective clothing, gloves and eye/face protection
- Use only in well-ventilated areas
- Avoid contamination of food
- Avoid release to the environment

First-Aid Measures
- Refer to Cidexplus® OPA Product Information

4. Directions for Use

Activation
a. Does not require activation before use.
b. Test the activated solution with compatible test strips prior to each use. The minimum effective concentration (MEC) of ortho-Phthalaldehyde is 0.3%.

5. Cleaning

Feces, mucus, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus® OPA Solution.

Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus® OPA Solution.

Clean and rinse lumens of hollow instruments before filling with Cidexplus® OPA Solution.
6. **Usage**
   a. Test the solution with Solution Test Strips prior to each use.
   b. Immerse cleaned and rough dried medical devices completely in the Cidexplus® OPA Solution, filling all lumens.
   c. Leave medical devices completely **immersed for at least 12 minutes at room temperature** for High-Level Disinfection.
   d. Rinse with sterile water
   e. Used ortho-Phthalaldehyde solution is neutralized as per Product Information and is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal

Revised:
FLEXIBLE NASOPHARYNGEAL LARYNGOSCOPE

POLICY:
Flexible nasopharyngeal laryngoscopes are cleaned and disinfected consistent with LHH Infection Control Policies G4 "Cleaning of Reusable Medical Instruments", G7 "High-Level Chemical Disinfection" and F9 "Chemical Sterilization Standards".

PURPOSE:
To destroy microorganisms both cleaning and high-level disinfection are necessary to prevent disease transmission.

PROCEDURE:
1. Classification and processing requirements

A flexible nasopharyngeal laryngoscope is classified as a semi-critical medical device because during use the device makes contact with mucous membranes but does not usually penetrate normally sterile areas of the body. Refer to Infection Control Policy G2, “Classification of Reusable Medical Devices and Processing Requirements.”

High-Level Disinfection is acceptable for processing semi-critical medical devices.

2. High-level disinfection on the day of use

a. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

b. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, “High-Level Chemical Disinfection.”

c. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

d. Prepare the proper container for the high-level disinfectant and pour the solution into it.

e. Immerse the scope for the scope and disinfectant manufacturers’ recommended time and temperature conditions for high-level disinfection.

f. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

   NOTE: These conditions should be strictly followed since over immersion may damage the scope.

g. Using sterile gloves:
   - Remove the scope from chemical solution.
   - Rinse the scope thoroughly using sterile water.
   - Dry the scope thoroughly using sterile gauze.
3. Cleaning after procedure and use of the laryngoscope

   Immediately after removing the laryngoscope from the patient:

   A. Gently wipe all debris off insertion tube with gauze soaked in freshly prepared enzymatic detergent solution.
   B. Ensure all debris has been removed from the insertion tube, deflection section, and illumination/observation windows.
   C. Transfer the laryngoscope from the procedure room to the reprocessing room in a leak proof enclosed container.
   D. In the reprocessing room thoroughly but gently wash the entire outer surface of the scope with a mild pH enzymatic detergent following the manufacturer’s instructions.
   E. Thoroughly rinse the scope with potable water and gently dry or allow to air dry.

4. High-level disinfection after initial cleaning procedure

   A. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).
   B. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, “High-Level Chemical Disinfection.”
   C. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.
   D. Prepare the proper container for the high-level disinfectant and pour the solution into it.
   E. Immerse the scope for the scope and disinfectant manufacturers’ recommended time and temperature conditions for high-level disinfection.
   F. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.
      NOTE: These conditions should be strictly followed since over immersion may damage the scope.
   G. Using sterile gloves:
      - Remove the scope from chemical solution.
      - Rinse the scope thoroughly using sterile water.
      - Dry the scope thoroughly using sterile gauze.

5. Storage

   Store the laryngoscope in a clean, dry, dust-free locked storage cart. The storage area will be cleaned with a hospital approved disinfectant each time the laryngoscope is used. The laryngoscope will be placed in a cleaned tray lined with a new chuck and locked until the next time it is used.

6. DISPOSAL OF Ortho-PHTHALALDEHYDE SOLUTION

   Used ortho-Phthalaldehyde solution is neutralized as per Product Information and placed in a sealed container provided by the Industrial Hygienist and will be picked up by Facility Services for disposal.
References:
LHH Infection Control Policy G2, “Classification of Reusable Medical Devices and Processing”
LHH Infection Control Policy G4, “Cleaning of Reusable Medical Instruments”
LHH Infection Control Policy G7, “High-Level Chemical Disinfection”
LHH Infection Control Policy F9, “Chemical Sterilization Standards”

Revised:
POLICY AND PROCEDURE FOR ORDERS FOR MEDICATIONS AND STANDING ORDERS

Policy:

Only medications prescribed by a physician, affiliated healthcare practitioners credentialed by the medical staff, dentist, or podiatrist will be administered to a resident and no standing orders* will be used.

Purpose:

To ensure proper administration of medications to residents.

Procedure:

I. All prescription orders must be in writing or electronically prescribed and should contain the following:
   A. Date and time order is written
   B. Patient name and medical record number
   C. Medication name (generic preferred)
   D. Strength or concentration
   E. Dose
   F. Frequency or time of administration of the medication
   G. Route, e.g. PO, IM, SC, IV or rectal
   H. Rate of administration for continuous IV medications
   I. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.
   J. Duration of therapy or quantity if applicable (e.g. antibiotics, outpatient prescriptions, pass medications)
   K. Prescribing practitioner signature (written or electronic)

II. All verbal or telephone orders to the nurse or pharmacist should be immediately recorded in the resident's chart and signed by the prescriber within 48 hours for the acute unit and within five days for SNF units.

III. There will be no standing orders for medications or treatments.

III.IV. The electronic health record (EHR) “Current Medication List” is the chart order for SNF residents of the facility. EHR eprescription function requires quantity dispense and number of refills to be populated before prescription data can be eprescribed. Quantity dispensed will be per Pharm 02.01.00b. The “Current Medication List” verified by the provider each month (medication reconciliation) is considered the continuation order. If the medication is not able to be entered into the electronic health record (e.g. TPN,
compounded medications) a written order of the paper chart physician order sheet will be accepted. The provider signs a monthly re-cap (continuation) of these orders each month. Medications will be discontinued upon a discontinue order or per the automatic stop policy (Pharm 01.02.02).

IV.V. Residents have a right to elect the dispensing pharmacy. When using an outside pharmacy, the family assumes the responsibility for supplying correct, properly labeled medications on a timely basis. Such medications will be delivered directly from the resident’s pharmacy to Laguna Honda Pharmacy during our normal pharmacy hours. Such medications will be checked by Laguna Honda Pharmacy before delivery to the resident’s unit. Only those medications which have been ordered by the resident’s physician will be allowed.

A. Controlled Substances may not be obtained from another pharmacy unless approved by the Pharmacy Director.

V.VI. All signed physician’s orders will be sent to the pharmacy within 48 hours.

REVISED: 6/99DY, 9/00dy, 9/04dw, 4/11, 5/14, 2/15
REVIEWED: 02/05DW, 02/06, 01/08, 04/09, 2/10, 4/12, 8/13, 2/15

*Standing orders are defined Per California Code of Regulations Title 22 §72109 Standing Orders are orders written which are used or intended to be used in the absence of a prescriber’s specific order for a specific patient.
POLICY AND PROCEDURE FOR AUTOMATIC STOP ORDERS

Policy:
Pharmacy and Therapeutics Committee will establish stop-orders on various classes of medications.

Purpose:
To limit the duration of medication therapy in the event the physician has not done so by specifying a number of days or number of doses.

A. The Stop Order Policy is applicable to all medication as specified below.

B. The attending physician will be notified of stop orders before the medication order expires so that the medications are renewed if necessary to assure continuity of treatment.

C. Such notification will be documented by the licensed nurse in compliance with the medical records policy.

D. The Stop Order Policy will be available in each medication room or nursing station electronically on the Pharmacy Policy and Procedure Page.

Procedures:
Medication Categories with a Specific Stop Order include the following:

1. Schedule II Medications - Stop order in seven (7) days.
   Examples include:
   - Codeine
   - Fentanyl patches (Duragesic)
   - Hydrocodone and acetaminophen (NorCo, Vicodin)
   - Hydromorphone (Dilaudid)
   - Methadone
   - Methylphenidate (Ritalin)
   - Morphine (Oramorph SR, MS Contin, Roxanol)
   - Oxycodone
   - Oxycodone & acetaminophen (Percocet)
   - Oxycodone & aspirin (Percodan)
   - Tincture of Opium

2. Schedule III - Stop Order in 45 days.
   - Acetaminophen with Codeine 15 mg, 30 mg, 60 mg (Tylenol #2, 3, 4)
   - Dronabinol (Marinol)
   - Hydrocodone & acetaminophen (Vicodin)
   - Testosterone (Delatestryl)
3. Schedule IV - Stop Order in 45 days

Alprazolam (Xanax)
Chlordiazepoxide (Librium)
Clonazepam (Klonopin)
Diazepam (Valium)
Lorazepam (Ativan)
Phenobarbital
Temazepam (Restoril)
Triazolam (Halcion)

4.2. Anticoagulants:

Unfractionated Heparin - 48 hours
Low molecular weight Heparin - twenty (20) syringes per dispensing and a maximum of two (2) dispensings
Warfarin - 7 days

NOTE: If the prescriber does not renew a warfarin or low molecular weight heparin order, he/she will be contacted to renew or discontinue it. If the prescriber is not readily available, warfarin/low molecular weight heparin may continue for up to 14 days or until contacted (it shall not be discontinued without a specific “D/C” order from the physician).

5.3. All orders for antibiotics, including those administered by the parenteral, oral, topical, and ophthalmic routes, unless otherwise specified by the prescribing physician, will have a stop order in seven (7) days. The seven (7) day stop order EXCLUDES antiviral, antifungal and antituberculosis agents.

NOTE: Antibiotic orders should preferably specify the dates of administration rather than the number ___of days.

6.4. Antiemetics, anti-diarrhea, antihistamines and cough and cold preparations will have an automatic stop order after seven (7) days unless the physician has specified a definite dc order date, or has written the prescription “for maintenance use”.

7.5. All Non-steroidal anti inflammatory agents (NSAIDS) will have an automatic stop of 7 days unless a specific number of days or “maintenance” is indicated on the order. NOTE: This policy does not apply to single daily doses of aspirin.

8.6. Genito-urinary antispasmodics (flavoxate (Urispas), hyoscyamine (Levsin), oxybutynin (Ditropan), propantheline (Pro-Banthine), tolterodine tartrate (Detrol) will have an automatic stop of 14 days unless the physician has specified a definite dc order date, or has indicated “maintenance” on the order.

9.7. All other medication classifications will be in effect for 45 days.

New: 4/93
Revised: 1/94; 4/98, 6/98, 11/99, 6/00, 11/00, 04/03, 04/04, 08/05, 05/06, 01/08, 4/11, 2/15
Reviewed: 04/09, 02/10, 4/12, 8/13, 4/14
POLICY AND PROCEDURE FOR GUIDELINES FOR VERBAL / TELEPHONE MEDICATION ORDERS

POLICY:
1. Verbal communication of prescription or medication orders is limited to situations in which immediate written or electronic communication is not feasible.
2. Verbal orders are not indicated when the prescriber is present and the patient's chart is available, except in an emergency situation, in which case a repeat-back is acceptable.
3. Verbal orders are not permitted for chemotherapy.
4. The following job categories are authorized to give verbal orders:
   4.1. Physician
   4.2. Affiliated Healthcare Practitioners credentialed by the medical staff
   4.3. Dentist
   4.4. Podiatrist
5. The following job categories are authorized to accept verbal medication orders:
   5.1. Licensed nurse (RN, LVN, LPT)
   5.2. Licensed Pharmacist
   5.3. Respiratory Therapist
6. Staff giving or accepting verbal orders are limited to only those orders within their scope of practice.

PURPOSE: To reduce errors associated with misinterpreted verbal or telephone communications of medication orders.

Procedure: See Hospitalwide Policy 25-03, Verbal / Telephone Medication Orders

Reviewed: 2/08, 4/09, 4/10, 04/11, 8/13
Revised 11/2010, 4/12, 5/14, 2/15
POLICY AND PROCEDURE FOR SAFE MEDICATION ORDERS

Policy:

Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal communication of prescription or medication orders is limited to situations in which immediate written or electronic communication is not feasible. Medication orders from physicians, dentists, podiatrists, and affiliated healthcare practitioners credentialed by the medical staff are accepted if they comply with the requirements listed below.

Purpose:

To ensure resident safety by reducing the potential for error or misinterpretation when orders are communicated.

Procedure: See Hospitalwide Policy for Safe Medication Orders 25-02

Revised: 4/11, 5/14, 2/15

Reviewed: 02/08, 04/09, 4/10, 4/12, 8/13
POLICY AND PROCEDURE FOR SCHEDULED TIME-OFF

Policy:

No more than 2 staff pharmacists may take scheduled time-off during the same period.

No more than 2 clinical pharmacists may take scheduled time-off during the same period.

No more than 1-2 pharmacy technician may take scheduled time-off during the same period.

Purpose:

To assure appropriate pharmacy staffing levels required to provide pharmaceutical care consistent with the Department's Mission.

Procedure:

1. Pharmacy staff will be supplied a vacation priority request form each fall to request time off for the following calendar year. These vacation requests will be approved on a seniority basis. The vacation approvals will be clearly indicated on a shared electronic calendar.
   
   a. During peak vacation periods (i.e. Christmas, New Year’s, Easter, school breaks), a rotation will be maintained by the Pharmacist in Charge / Pharmacy Director.
   
   b. If changes are desired amongst staff, mutual consent must be confirmed between the involved staff, and the changes must be approved by the Pharmacist in Charge/ Pharmacy Director.

2. Subsequent vacation requests will be approved as staffing allows on a first come first serve basis as outlined below.

   Except for peak times (described below #2), staff should submit their requests in writing to the Pharmacist in Charge / Pharmacy Director no less than 2 weeks prior to the first vacation or time-off day requested.

   a. The written request for time-off must indicate the inclusive date(s) of the requested time-off and the accrued time against which the time-off will be charged (e.g. vacation, compensatory time, etc.)

   b. The Pharmacist in Charge / Pharmacy Director will respond to the request in writing within 10 working days following receipt.

   c. Unless previously submitted requests for the time-off period have been approved, time-off will be approved on a seniority basis for overlapping/conflicting requests.

2. During peak vacation periods (i.e. Christmas, New Year’s, Easter, school breaks), a rotation will be assigned by the Pharmacist in Charge / Pharmacy Director.

   a. The rotational schedule will be posted at the beginning of every calendar year.
b. If changes to the rotation schedule are desired amongst staff, mutual consent must be confirmed between the involved staff, and the changes must be approved by the Pharmacist in Charge / Pharmacy Director.

New: 5/98 MP/SK
Reviewed: 02/05, 04/09, 2/10, 4/11, 4/12, 8/13
Revised: 02/06dw, 01/08, 2/15
POLICY AND PROCEDURE FOR SKILLED NURSING DISTRIBUTION OF MEDICATIONS AND MEDICATION ORDER PROCESSING

Policy:
The Pharmacy at Laguna Honda Hospital will have sole responsibility for distributing medications in the hospital and for establishing procedures for processing of medication orders.

Purpose:
To ensure proper supplies of medications to residents.

Procedures:

I. The Individual Resident Prescription System:

A. The physician writes or electronically prescribes new orders for residents. Monthly renewals on a physician’s order form for medications is accomplished thru the medication reconciliation process in the electronic health record or via a physician order form if the medication cannot be entered into the electronic health record.

B. New orders are either transmitted electronically via eRx, electronically reproduced facsimile or brought to the Pharmacy or transmitted by electronically reproduced facsimile. These orders are maintained electronically in the pharmacy information system, kept in the Pharmacy in Resident-specific files, and are used to record prescription-filled information.

C. The pharmacy will check each order against the resident's medication profile for incompatibilities, unusual dosages, and errors. The pharmacist shall require physician clarification of orders prescribed for unusual uses, as well as any other medication irregularities.

D. Each order is filled with the appropriate amount of medication.

1. For Skilled Nursing Facility residents, a 7-day supply of medication is issued.

2. For short-term medications written for a specific length of time only that amount which is required will be dispensed.

3. For "PRN" medications the amount dispensed will be estimated by the pharmacist, taking into account the rate of usage by the resident in the past; the condition written for e.g., pain,
sleep, etc; and the fact that "PRN" orders may be refilled by the nurse when more medication is needed.

E. Resident Transfers
1. When a resident is transferred within LHH from a SNF unit to another SNF unit, the nurse will send the resident's medication to the receiving unit.
2. When a resident is discharged / admitted to or from an acute unit, the resident's medications must be returned to pharmacy by the sending unit. New medications will be obtained by the receiving unit. If the pharmacy is closed at time of discharge / admission to or from the acute care unit, the nurse will send the medications to the receiving unit and these medications may be used temporarily until the pharmacy re-opens. Once the pharmacy re-opens new medications must be obtained.

F. A record of medications dispensed should be made in the resident's medication file to include: quantity of medication, prescription number, date and initials of pharmacist filling or checking the meds filled by a technician.

G. The prescription label for each resident will include:

- Resident's name.
- Amount of medication.
- Prescription number.
- Prescribing physician's name.
- Resident's medical record number.
- Date filled.
- Directions including rate of administration for IV medications.
- Manufacturer's name (if generic).
- Name of medication (generic or brand).
- Expiration date.
- Initials of technician or pharmacist filling prescription.

H. Discharges:
1. Cassette medications may be sent with the resident upon discharge unless one of the following situations exists:
   a) Physician specifies otherwise.
   b) Resident leaves without physician approval.
   c) Resident discharged to acute hospital or health care facility other than LHH.
   d) Medication discontinued prior to discharge.
   e) Labeled directions substantially differ from current orders.

2. Discharge meds will be dispensed in child-proof containers. Labels will be typed in lay-language

3. A record of the medications sent with the resident should be made in the resident's file to include: name of medication, prescription number, quantity of medication, date, and initials of pharmacist filling or checking the meds filled by a technician.

I. Passmeds: Medication Orders will be filled for resident's use on short-term passes, provided the physician has given orders for such medication use. (See Policy and Procedure 02.01.04, Pass Medication)
J. Orders for certain medications will not be filled, but will be available as floor stock items. These items include laxatives, vitamins, A & D ointment, petrolatum, antacids, acetaminophen, aspirin, or other approved medications. (See Section A, Floor Stock System)

K. Each resident's medication is placed in an individual cassette-held drawer which is labeled and designated for that resident.

L. The medications in the cassette-held patient drawers are delivered to the appropriate Unit on a cyclical basis and, in the case of refills, are exchanged for the previous cassettes.

M. The duplicate cassettes are returned to the pharmacy.

N. New physician's orders that are written during the interim period are accommodated in the following manner:

1. Orders that add medication to a resident's drug regimen are sent to the pharmacy to be filled and delivered to the Unit.

2. Orders that discontinue medication from a resident's drug regimen are sent to the Pharmacy, along with the discontinued med from the resident's drawer.

O. If a resident is transferred to a different Unit, the Unit nurse will include all of the resident's medications in the transfer to the new Unit.

P. All medications of a deceased resident will be returned to the pharmacy for disposal.

Q. All orders received will constitute a prescription and will be kept as required by State and Federal law.

R. Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room. (See Policy 02.03.00 for Supplemental Drug Room procedure.)

**NOTE:** Normal pharmacy hours are Monday through Friday, 8 a.m. to 5:30 p.m. and 9 a.m. to 4 p.m. on Sunday. On legal holidays the Pharmacy will be open from 8 a.m. to 4:30 p.m. The pharmacy will be closed on Thanksgiving and Christmas.

Reviewed 06/03dw, 02/06, 01/08, 04/09, 4/12, 8/13
Revised 06/07, 02/08, 05/08, 2/10, 5/11, 4/14, 2/15
POLICY AND PROCEDURE FOR DISPOSITION OF MEDICATIONS

Policy:

All discontinued medications will be returned to the pharmacy for disposal, return to stock, or hold. Medications will be returned to the pharmacy when resident is deceased, discharged, or the medication is discontinued.

Purpose:

To ensure residents' medications are appropriately disposed or destroyed.

Procedures:

I. Returned medications from Automated Dispensing Cabinets (ADCs). See Automated Dispensing Cabinet Dispensing Procedures (PHAR 09.00)

II. Returned medications from units
   A. Controlled Substances: Schedule II, III, IV, and V not in ADC
      1. Sign-out sheets with unused medications are returned to pharmacy.
      2. Sheet must be properly signed.
      3. Amount of medication returned must correspond with sign-out sheet inventory.
      4. Returned medications, if in unit dosages, properly labeled and identified, will be re-issued to other units.
   B. Nonscheduled Medications
      1. Pharmacist will check all medications returned to the pharmacy.
      2. Unopened, properly labeled medications may be returned to stock and credit applied when appropriate.
      3. Contaminated medications will be disposed.
      4. Unidentifiable medications will be disposed.
      5. Outdated medications will be returned to manufacturer for credit.
III. Medications on Hold

A. Medications may be temporarily held (e.g. resident discharged to acute hospital outside LHH but is expected to return, or medication temporarily stopped) in the Pharmacy until resident returns to LHH or until a temporarily discontinued medication order is renewed. The Nurse will bag the medications and label them with resident’s name, date, and write the word “HOLD”, and forward to Pharmacy.

IV. Pharmaceutical Waste Disposal

A. Pharmaceutical Waste Containers (Blue & White) shall be used to dispose of partially full or used medication (e.g. pills, capsules, ointments, paste, and patches) that are not hazardous. Environmental Services will dispose through a certified medical waste disposal vendor.

B. Controlled substances returned from units that are not suitable for use due to damaged packaging or part of patient personal medications upon admission stored in the pharmacy for greater than 30 days will be disposed via the Cactus Sink which makes them irretrievable. The waste will be documented by two staff who witness the destruction.

B-C. DISPOSAL of Hazardous Drug Waste: See Hospitalwide policy on Hazardous Drugs Management

Reviewed: 0403dw, 06/04dw, 02/06, 01/08, 04/09, 2/10, 5/11, 4/12, 8/13
Revised: 06/08dw, 10/09, 4/10, 2/15
POLICY AND PROCEDURE FOR EMERGENCY AND SUPPLEMENTAL MEDICATION SUPPLIES

Policy:
An emergency medication container will be kept on each unit and supplemental medication supplies will be kept in the Supplemental Medication Room.

Purpose:
To have medications available in case of need and to make sure that items are replaced when used.

Procedures:
A. SUPPLEMENTAL MEDICATION AUTOMATED DISPENSING CABINET (ADC) – Also see PHAR 09.00 Automated Dispensing Cabinets

1. The Supplemental Medication ADC is to be used only on nights, weekends, and holidays when the pharmacy is closed.

2. The nursing supervisor is the only authorized person to have the key to the room containing the Supplemental Medication ADC.

3. The nursing supervisor will be notified by either MD or RN as to which emergency medication is needed.

   Nursing supervisor will consult the supplemental medication list posted on the LHH Pharmacy Policy Page to see if the medication is available.

4. If the medication is available, the nursing supervisor and RN will proceed to the Supplemental Medication ADC.

5. The nursing supervisor and RN will proceed to the Supplemental Medication ADC.

6. The nursing supervisor will dispense requested medication to RN.

7. An electronic record will be maintained, which includes the medication issued, date, amount issued, resident's name, and name of the nurse supervisor.

8. Re-secure Supplemental Medication Room by checking door is locked when exiting.

9. Before dispensing to the unit, the nursing supervisor shall check the medication ordered against patient's listed drug allergies and document this by circling the allergy information on the Physicians Order Sheet. If an allergy is noted the physician should be contacted.

10. If the requested medication is not available from the Supplemental Medication ADC, the Nursing Supervisor will use the OmniExplorer feature to determine if the medication is available in another ADC within the facility. If the medication is not available in any ADC the Nursing Supervisor will check with the physician to see if an available medication can be substituted, or if therapy can wait until the Pharmacy reopens. If not,
the nursing supervisor will call a pharmacist at home to come to the hospital and dispense the medication from the Pharmacy.
11. If a LHH pharmacist cannot be reached or is unavailable:
   a. The nursing supervisor will call SFGH Inpatient Pharmacy at (415) 206-8460 to check availability of the medication ordered. If available, the nursing supervisor will fax the prescription to SFGH Inpatient Pharmacy (415) 206-5472.
   b. The amount dispensed will be limited to the amount necessary for doses to be administered until the LHH Pharmacy reopens.
   c. The nursing supervisor shall arrange for a taxi to be sent to SFGH to pick up the medication and return it to LHH. The nursing supervisor acknowledges receipt of medication by faxing a form to SFGH Pharmacy. The medication will be distributed to the unit.
   d. This procedure does not apply to any controlled substance.

12. Medications removed from the Supplemental Medication ADC after hours will be replenished as soon as the Pharmacy is open.

13. Pharmacy staff will restock the ADC using the procedures outlined in PHAR 09.00.

14. Those medications found in the Supplemental Medication Room are listed on attachment 2.
   a. When drugs are added or deleted from the Supplemental Medication ADC, a pharmacist shall revise the list.
   b. Revised lists shall be distributed to each holder of a Pharmacy Policy and Procedure Manual and to Nursing.

B. EMERGENCY MEDICATION CONTAINER:

1. Emergency medication supplies will be kept in a separate, clearly labeled container in a locked cabinet in each medication room.

2. This container will be sealed with a tamper-proof device that will show that it has been opened.
3. Each Emergency Medication Container will contain the following:

**Emergency Drug Supply from Pharmacy**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Qty</th>
<th>Exp.Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol nebulizer solution unit dose</td>
<td>#3</td>
<td></td>
</tr>
<tr>
<td><em>Aspirin 81mg chewable tablet</em></td>
<td>#4</td>
<td></td>
</tr>
<tr>
<td>Dextrose 50% 50ml Syr.</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine 50mg/ml 1ml vial</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:1000 1ml amp</td>
<td>#3</td>
<td></td>
</tr>
<tr>
<td>Furosemide 40mg/4ml 4ml vial</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Glucagon 1mg inj.</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>Glucose tablet</td>
<td>#10</td>
<td></td>
</tr>
<tr>
<td>Methylprednisolone 125mg/2ml vial</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Naloxone 0.4mg/ml 1ml amp</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Nitroglycerin 1000gr (0.4mg) S.L. tab</td>
<td>#25</td>
<td></td>
</tr>
<tr>
<td>Nitroglycerin Oint. 2% 1gm foil pack</td>
<td>#3</td>
<td></td>
</tr>
<tr>
<td>Lorazepam 2mg/ml vials Diazepam 10mg rectal gel</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Morphine: (minimum of 1)</td>
<td></td>
<td>Sign out</td>
</tr>
</tbody>
</table>

4. A sign-out card will be placed on the container to record medication used. The person taking the medication will record:

- Name, dose, and quantity of the medication
- Name of resident.
- Date and time of administration of the medication.
- Signature of person administering the medication.

5. Whenever the container is opened, the nurse on the unit should notify the Pharmacy. Nursing staff will contact the pharmacy to stock and reseal the Emergency Container. Notification and replacement of used medications must be done within 72 hours.

6. The Pharmacy Service will check the Emergency Container monthly for freshness and completeness of contents. They will replace missing medications or items and reseal the container.

7. The pharmacist doing the checking will sign and date the check card on the container.

C. **CRASH CART**

1. Crash carts will be located on each floor of the Main Buildings, and on each floor of the Pavillion, to be used in accordance with the Code Blue Policy of the Hospital.

2. The Pharmacy will be responsible for keeping the crash carts properly stocked with drugs.
   a. The pharmacist, or technician under pharmacist supervision, will fill a tray with crash cart medications and complete a contents sheet (Attachment 3) by writing in the expiration date of each drug in the assigned area.
b. The earliest expiration date will be circled and this information will be copied onto a sticker to be placed on the outside of the crash cart when the tray is exchanged. The pharmacist checking the tray will sign and date the bottom of the contents sheet and include the sheet on top of the tray.

c. The pharmacist will place the tray with contents sheet situated for easy viewing in the tamper-evident plastic bag. Affix the sticker with the earliest expiration date information onto the sealed bag for later transfer to the outside of the crash cart when the tray is exchanged.

d. The float technician will be responsible for keeping 3 trays pre-packaged ready to exchange at all times. In his/her absence, the drug box technician will be responsible.

3. After each use the Pharmacy will be notified by Central Supply to restock the used medications.

   a. The pharmacist will bring up to Central Supply a sealed prepackaged crash cart medication tray and exchange it for the opened tray. If the sealed bag has not been opened, the pharmacist will double check the contents to make sure the tray is intact and that medications are not expired.

   b. The pharmacist will place the sticker with the earliest expiration date information on the outside of the crash cart.

   c. The pharmacist will lock the crash cart with a tamper-evident lock.

4. The Pharmacy will check the crash cart monthly for outdated, contaminated, or deteriorated medications, and replace as needed.

   a. The pharmacist will ensure that the earliest expiration date on the contents list inside the sealed tray matches the sticker on the outside of the crash cart.

   b. The pharmacist will also check the batteries of the laryngoscope located in the respiratory treatment drawer during the monthly cart check. Central Supply will check the batteries when the carts are brought back for exchange. If the batteries do not operate, the person checking will replace the batteries.

   c. The pharmacist will sign and date the card in the cart indicating that the monthly check has been done and lock the crash cart after he/she has finished.

5. Contents of the crash cart are listed on Attachment 3.
Policy:

The Pharmacy and Therapeutics Committee shall determine drugs that may be therapeutically interchanged by the pharmacist without consultation with the physician. Generic substitution of bioequivalent drugs is permitted unless a written order by the physician specifies that the drug is to be dispensed as written.

Purpose: To provide timely, efficacious, and cost efficient pharmaceutical care services.

Procedure:

1. The Pharmacy and Therapeutics Committee shall review all pertinent literature and analyze the cost benefit relationship of drugs proposed for therapeutic interchange.
2. Upon determination of efficacy, safety and cost effectiveness, the Pharmacy and Therapeutics Committee shall approve the addition of the proposed drugs to the Pharmacy Department Policy and Procedure for Therapeutic Interchange.
3. The Pharmacy and Therapeutics Committee may also remove drugs from the Policy and Procedure at its discretion.
4. The Chairman of the Pharmacy and Therapeutics Committee and the Pharmacy Director shall communicate changes to the Therapeutic Interchange Policy and Procedure to the Medical, Pharmacy, and Nursing staff of the Hospital.
5. Pharmacists may interchange drugs listed on the Policy and Procedure without first consulting with the physician.
6. If required to assure clarity and decrease the possibility for medication error, the pharmacist shall write document an order for the therapeutic interchange drug on the patient's chart.
7. Unless specifically prohibited by a written or electronic physician order, pharmacists may dispense bioequivalent generic medication.

NEW: 3/94 sk
Revised: 4/97, 6/99, 5/00dy, 8/01dy, 10/03dw, 2/15
Reviewed: 02/06, 01/08, 04/09, 2/10, 4/11, 5/12, 8/13
Laguna Honda Hospital Temporary Morgue Services

POLICY:
1. Bay Area Cremation and Funeral Services (BAC) will provide temporary morgue services to Laguna Honda until such time as Laguna Honda has completed its physical plant to restore morgue services on its premise.

2. Unless private funeral pre-arrangements are made, BAC serves as the Laguna Honda morgue and will pick up the bodies of deceased Laguna Honda residents.

3. The Admissions and Eligibility Department (A&E) is responsible for oversight and management of the morgue contract.

PURPOSE:
To describe roles and responsibilities of Laguna Honda staff and BAC related to morgue services.

PROCEDURE:
1. **Arrangement for BAC to Pick Up Decedents**
   a. Laguna Honda neighborhood Nursing staff will contact BAC at 800-916-4888 or 415-508-0823 to arrange pick-up of decedent at a mutually agreed upon time.
   
   b. BAC will dispatch staff to Laguna Honda within two hours of notification, 24 hours per day, seven days per week, 365 days per year.
   
   c. BAC will use the loading dock entry and service elevator to pick up and transport decedents out of the facility.
   
   d. During business hours Monday–Friday (0800–1630), BAC staff will go to the Admissions & Eligibility (A&E) department to sign the death registry, attest to pick-up, and verify the location of the decedent.
      
      i. The A&E Financial Counselor will have BAC sign and date the death registry.
      
      ii. BAC will proceed to the neighborhood to pick up the body and transport the body to the BAC facility at 1555 Yosemite Street, San Francisco, CA 94124.
   
   b. At all hours when A&E is closed, i.e., from 1630 to 0800 and on weekends and holidays, BAC staff will go to the Nursing Office to sign the death registry for attestation and receive neighborhood verification of decedent.
      
      i. The Nursing office will notify the neighborhood staff that the decedent is released for pick-up after BAC signed and dated the death registry.
2. Viewing of Decedents
   a. If family members have expressed an interest in viewing the body, they will be encouraged to do so in the resident’s Laguna Honda room as soon as possible.

   b. In the event that the family is unable to view at Laguna Honda in a reasonable time frame and requests viewing at BAC, Nursing will indicate it on BAC form. The original copy of the form will be sent to BAC, a copy will be faxed to A&E at 415-682-5689 and copy for the medical record.

   c. The family will be advised to call BAC as soon as possible to arrange a time for viewing.

   d. One viewing at BAC will be provided at Laguna Honda’s expense. Additional viewings, pre-arranged directly with BAC staff, may occur at family’s expense. Payment must be made directly to BAC.

3. Disposition of Decedents
   a. The Laguna Honda A&E financial counselor will continue to coordinate with family members, Public Administrator / Public Guardian (PA/PG) Office, and the Office of the Chief Medical Examiner to arrange final disposition of decedents remaining in BAC.

      i. Laguna Honda A&E will notify BAC of the designated mortuary assigned to pick up decedent. A four-hour notice is required for pick-up.

      ii. BAC will be available to arrange for decedent pick-up by the mortuary during normal business hours Monday–Friday 0800–1630.

      iii. After normal business hours, BAC will advise the designated mortuary of the additional fee of $250.00, which is charged to the family.

4. Disposition of Medical Examiner Cases
   a. In the event that the death is reportable to the Office of the Chief Medical Examiner, the attending physician is responsible for notifying the Office. In these cases, the body cannot be released until cleared by the covering M.D.

   b. After notification, the Medical Examiner may do one of the following:

      i. Approve release of the body;
      ii. Request to examine the body prior to release;
      iii. Request to pick up the body and transport to the Office of the Chief Medical Examiner.
5. BAC Site Visits  
a. The A&E Supervisor will make monthly scheduled visits to BAC to verify decedents and ensure that Laguna Honda records are consistent with actual decedents being held at BAC. A&E will contact BAC 24 hours prior to visit.

6. Invoice Review and Approval  
a. BAC will send a monthly invoice of services provided in the prior month.

b. The A&E Supervisor will review invoices to verify their accuracy and that they reflect actual services provided.

c. The A&E Supervisor will report discrepancies via email to the A&E Manager.

d. Once the invoice is reviewed and signed by the A&E Manager, the payment request form is completed and submitted to the A&E Manager along with the following forms:

   i. Original Invoice;
   ii. Direct Payment Voucher;
   iii. Copy of death log with name(s) of decedent(s) and pick-up date;
   iv. If applicable, a copy of authorization for viewing (BAC release form).

7. Payment Request  
a. Payment request requires approval signatures of A&E Manager and Director of Patient Financial Services.

b. A&E will deliver signed payment request to the Accounting Department for final processing and payment.

8. Contacts  
a. For immediate assistance related to decedent pick-up, contact the Nursing office at telephone number 415-682-1502.

b. For all other matters, contact the Admissions and Eligibility Department at telephone number 415-682-5686
ATTACHMENT:
None

REFERENCE:
LHHPP 24-02 Notice of Resident Death
NPP D8.0 Post-Mortem Care
NPP D8.0 Post-Mortem Care—Appendix 1: Supportive Conversation with Family when Notifying of Resident’s Demise

Most recent review: 12/08/29 (Year/Month/Day)
Revised: 11/03/24, 11/05/13
Original adoption: 11/03/24
Laguna Honda Hospital
Infection Control Manual

SECTION A: Infection Control Program

TITLE: INFECTION CONTROL PROFESSIONALS

Purpose:
The Infection Control Program at Laguna Honda Hospital (LHH) is staffed with professionals who are trained and qualified to perform the necessary functions of infection control and health care epidemiology.

Statement of Policy:
Infection Control Professionals (ICPs) have a broad knowledge base of infection control practice that includes: epidemiology, infectious diseases, microbiology, statistics, resident care practices, sterilization and disinfection, quality management, adult education, product evaluation, environmental health, employee health, public health, and consultation.

Procedure:
The ICPs may be registered nurses or other health care professional (e.g. RN, BSN, MD, PhD, MPH, MS, or other appropriate Masters Degree). Training in statistical methods, epidemiology, and infection control practices are mandatory. Certification in Infection Control (CIC) is encouraged.

The ICPs supervise and coordinate the Infection Control Program under the guidance of the Infection Control Committee Chair(s). The ICPs report to and are directed and evaluated by the Chairperson(s) of the Committee.
Duties of the Infection Control Professional (ICP) include:

Surveillance:

1. Assume responsibility for surveillance, under the direction of the Committee and Chairpersons, to identify infection risks to residents and personnel.

2. Coordinate the investigation of infection exposure incidents or outbreaks.

3. Work with Infection Control Chairs and Committee to plan and implement epidemiological studies necessary for control of outbreaks of infection. Use statistical analysis as appropriate to judge significance of data.

4. Request or take specimens for culture from residents, personnel or environment in order to determine appropriate Infection Control measures and make independent decisions or take actions on corrective preventive measures, within the guidelines of the Committee.

5. Maintain Infection Control information and record keeping.

Program, Policy, and Decision Support:

1. Provide consultation to Department Heads for development of departmental infection control policies and procedures, and collaborate with Nursing Service, physicians, hospital departments and the Infection Control Committee to develop appropriate infection precautions.

2. Evaluate Departments' Infection Control policies/procedures for compatibility with Hospital policy and State Licensing regulations. Confer with Department Heads on appropriate changes.

3. Monitor and assist with implementation of programs to minimize infectious hazards in the environment through interpretation of policies to Department Heads, and inform Department Heads of observed unsafe practices.

4. Coordinate application of Infection Control procedures throughout the Hospital by communicating and interpreting policies to staff. Maintain close communication with Nurse Managers, physicians, department supervisors and microbiology laboratory in order to ensure use of correct methods and be aware of problems which need further work or require Committee action.
Evaluation of Policies, Procedures, and Products relating to Sterilization and Disinfection:

1. Evaluate cleaning, sterilization, disinfection, and decontamination procedures for acceptability by community standards; interpret regulations to personnel responsible for these functions; meet and confer to solve problems in this area and teach principles of sterilization and disinfection to appropriate personnel.

2. Evaluate medical products and disinfectants in consultation with the Product Evaluation Committee to determine acceptability for use according to standards of practice, current regulations, and Committee recommendations.

Committee Membership and Participation:

1. Participate as an active member of the Infection Control Committee. Provide information to Committee on effectiveness of Infection Control Programs, problems requiring action, and contribute to development of new policy and procedure.

2. Gather information from professional literature and participate in professional groups outside the Hospital to determine community standards of infection control practice. Communicate this information to the Infection Control Committee for consideration.

3. Interpret Infection Control Committee policies to department heads and inform leadership of any observed unsafe practices.

4. The ICP is an active member of the Safety Committee, and Product Evaluation Committee and provides direct communication between those committees and the Infection Control Committee.

Education and Training:

1. Teach Infection Control principles and their application to Hospital Departments including all levels of personnel.

2. Consult with the Department of Education and Training (DET) regarding teaching of infection control policies and practices, and appropriateness of teaching materials (i.e. audio visuals) used by DET. Provide to DET updates on changes in regulations and recommendations which may effect educational content.
3. Serve as a resource on Infection Control to the community outside the hospital through consultation and teaching within limits set by the Committee.

4. The ICP is a liaison with other units in the Health Department outside the LHH setting.

5. The ICP will perform other duties related to Infection Control as prescribed by the Committee Chairperson(s).
Laguna Honda Hospital
Infection Control Manual

SECTION A: Infection Control Program

TITLE: DEMOGRAPHICS OF LAGUNA HONDA HOSPITAL

Purpose:
LHH has an Infection Control Program based on an ongoing assessment of the resident population.

Statement of Policy:
The plan for surveillance and reporting at Laguna Honda Hospital (LHH) reflects the important demographic features of the Hospital and the population it serves.

Procedure:

1. LHH is a long-term care and rehabilitation center serving the city and county of San Francisco. The geographic area served by LHH represents an inner city urban community. The residents served have specialized problems which the hospital categorizes into four specific cluster areas: Psychosocial, Complex Restorative, Chronic and Dementia.

2. LHH provides a broad range of resident services including:

   AIDS Unit     Skilled Nursing Units
   Rehabilitation SNF Unit     Medical Clinic
   Surgical Clinic     Rehabilitation Acute Unit
   Hospice Unit     Medical Acute Unit
SECTION A: Infection Control Program

TITLE: NOSOCOMIAL INFECTION DEFINITIONS

Purpose:

To monitor the occurrence of nosocomial infections and to develop intervention strategies to reduce nosocomial infections requires the application of consistent criteria for defining infection.

Statement of Policy:

The Infection Control Program has adopted Center for Disease Control (CDC) definitions for nosocomial infections for performing surveillance to ensure consistency and reproducibility.

Procedure:

1. Performing surveillance for nosocomial infections in a hospital-type setting requires the interpretation of clinical, laboratory, and other diagnostic information. The data gathered on each resident must satisfy the criteria for a nosocomial infection according to the established CDC definitions.

2. The CDC definitions may be applied for defining unit-based/housewide nosocomial infections in acute hospitalized residents, rehabilitation residents, psychiatric residents and residents in the skilled nursing facility.

3. Criteria for infections are based on the best information available. While all clinicians may not agree with the criteria, it is important to consistently use the CDC definitions so rates can be appropriately compared.

Note: For healthcare associated infection definitions for residents in alternative care settings (such as Adult Day Health), Infection Control staff should be consulted for assistance in developing/adopting definitions for surveillance initiatives.
4. Infection is defined as a local or systemic host response, typically inflammatory, to invasion by a microorganism(s) or resulting from its toxin.

5. To be considered nosocomial, there must be no evidence that the infection was present or incubating at the time of hospital admission.

6. Identification of Infections Using Laguna Honda Hospital (LHH) Data:
   - Information used to determine the presence and classification of a nosocomial infection should be a combination of clinical data and results of laboratory and other tests.
     - Clinical evidence may be derived from direct observation of the infection site, or review of the information in a resident's chart or other unit records.
     - Laboratory evidence may include results of cultures, antigen or antibody detection tests, or direct visualization methods.
     - Other diagnostic tests may include routine x-rays, ultrasound, CT scan, MRI, endoscopic procedures, biopsies, or needle aspiration.

7. Diagnosis of Infection by a Physician:
   - A physician's diagnosis of infection derived from direct observation during a procedure or from clinical judgment, is an acceptable criterion for an infection unless there is compelling evidence to the contrary (i.e., presumptive diagnosis that was not substantiated by subsequent studies).

8. Sources for Nosocomial Infection:
   - Nosocomial infections may be caused by infectious agents from endogenous or exogenous sources.
     - Endogenous sources are body sites that are normally inhabited by microorganisms, including the skin, nose, and mouth, GI tract, or vagina.
     - Exogenous sources are those external to the resident, such as health care workers, visitors, resident care equipment, medical devices, or the hospital environment.

9. Infections Discovered After LHH Discharge:
   - Infections that are acquired in the hospital and become evident after discharge are considered nosocomial infections.
10. **Exclusion Criteria:**
   - Infections associated with complications or extensions of infections already present at hospital admission are not considered nosocomial infections, unless a change in pathogen or symptoms strongly suggests the acquisition of a new infection.

   - Colonization is a condition which is not considered an infection. Colonization is defined as the presence of microorganisms on skin or mucous membranes, in open wounds, or in excretions or secretions, not causing adverse clinical symptoms.

   - Inflammation that results from tissue response to injury or stimulation by noninfectious agents (i.e., chemicals) is not considered an infection.

Attachment: CDC Definitions of Nosocomial Infections used to define the 48 specific nosocomial infections that may be included in surveillance at LHH.